

WRITE IN INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

10283

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

Village or City

Port Deposit

(No. ....)

St. .... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

John B. Abrahams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

May 2

(Month)

(Day)

1853 (Year)

7 AGE

77yrs. 4 mos. 18 ds. or min.?If LESS than  
1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)Light Housekeeper  
Laysan School

9 BIRTHPLACE

(State or country)

MD

10 NAME OF FATHER

Joseph G. Abraham

11 BIRTHPLACE OF FATHER

(State or country)

MD

12 MAIDEN NAME OF MOTHER

Susanita Reynolds

13 BIRTHPLACE OF MOTHER

(State or Country)

MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John B. Abrahams  
Port Deposit, MD

15

Filed

9/22

1930

L. J. Sanders

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 20, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Sept 2 - 1930 to Sept 20, 1930that I last saw him alive on Sept 20, 1930and that death occurred on the date stated above, at 12:30 m.

The CAUSE OF DEATH \* was as follows:

Artero-Sclerosis(Duration) 8 yrs. .... mos. .... ds.Contributory  
SecondaryChronic Myocarditis(Duration) 5 yrs. .... mos. .... ds.

(Signed)

G. D. Benson

M. D.

9/20 1930 (Address) Port Deposit, MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Hill Cem.Sept 23, 1930

20 UNDERTAKER

ADDRESS

Lee A. Patterson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

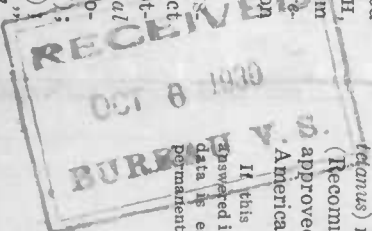
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

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## 1 PLACE OF DEATH

County Cecil

01518

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Port Deposit (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Tillie Acker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH  
March 12, 1870  
(Month) (Day) (Year)7 AGE  
59 yrs. 10 mos. 24 ds. or 59 min. ?  
If LESS than 1 day.... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country) Balto. Md.10 NAME OF FATHER  
Henry Levy11 BIRTHPLACE OF FATHER  
(State or country) Germany12 MAIDEN NAME OF MOTHER  
Rose13 BIRTHPLACE OF MOTHER  
(State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. B. Levy  
(Address) Have He Place15 Filed 2/8 19230 L.F. Jander  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Feb. 6, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
May 29, 1929, to Feb. 5, 1930,  
that I last saw him alive on Feb. 5, 1930,  
and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis  
Chronic Endocarditis  
Arteriosclerosis & Hypertension  
(Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Signed) C. J. Benson M. D.  
2/7 1930 (Address) Port Deposit, Md.

\*State the Disease Causing Death, or, 10 deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL  
Abraham Friendship Co.  
Balto. Md.DATE OF BURIAL  
Feb. 9, 193020 UNDERTAKER  
David Sandheim  
ADDRESS  
11820 W. Mt. Royal AveIf more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. Balto. Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Gold mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Insultion," "Miasmata," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 7 1920

BUREAU V

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<b>1 PLACE OF DEATH</b> County <u>Cecil</u> near <u>Elkton</u> Village or City <u>Elkton</u> (No. _____) St. _____ Ward _____			14843 187-C STATE OF MARYLAND <b>CERTIFICATE OF DEATH</b> Registration Dist. No. <u>92</u>		
<b>2 FULL NAME</b> <u>Morris Adelsnoki</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
<b>PERSONAL AND STATISTICAL PARTICULARS</b>					
<b>3 SEX</b> <u>Male</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> <u>No information</u> (Write the word)	<b>16 DATE OF DEATH</b> <u>December 5<sup>th</sup>, 1930</u> (Month) _____ (Day) _____ (Year) _____		
<b>6 DATE OF BIRTH</b> <u>No information</u> (Month) _____ (Day) _____ (Year) _____			<b>17 I HEREBY CERTIFY, That I attended the deceased from</b> <u>192</u> to <u>192</u> that I last saw him <u>alive</u> on <u>12/5</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2.30 A. m.</u> The CAUSE OF DEATH * was as follows: <u>Fractured Skull</u>		
<b>7 AGE</b> <u>apparent 35 years</u> yrs. _____ mos. _____ ds. _____ or _____ min.?			If LESS than 1 day _____ hrs. _____ min.?		
<b>8 OCCUPATION</b> (a) Trade, profession or particular kind of work <u>No information</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			<b>Contributory Secondary</b> <u>Auto Accident</u> (Duration) _____ yrs. _____ mos. _____ ds.		
<b>9 BIRTHPLACE</b> (State or country) <u>Va</u>			(Signed) <u>Howard W. Green</u> <u>12/5</u> , 19 <u>30</u> (Address) <u>Elkton Md</u> (Duration) _____ yrs. _____ mos. _____ ds.		
<b>PARENTS</b>	<b>10 NAME OF FATHER</b> <u>Aaron Adelsnoki</u>		State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Va</u>		<b>18 LENGTH OF RESIDENCE</b> (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	<b>12 MAIDEN NAME OF MOTHER</b> <u>No information</u>		Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
	<b>13 BIRTHPLACE OF MOTHER</b> (State or Country) <u>No information</u>		<b>19 PLACE OF BURIAL OR REMOVAL</b> <u>Richmond Va</u> <b>DATE OF BURIAL</b> <u>Dec 7, 1930</u>		
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Hospital record</u> (Address) <u>Elkton Md</u>					
<b>15 Filed</b> <u>Dec 6</u> 19 <u>30</u> <u>J. Frank Zager</u> Registrar			<b>20 UNDERTAKER</b> <u>H. W. Pippin</u> <b>ADDRESS</b> <u>Elkton Md</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 7 1901

BUR

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

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1 PLACE OF DEATH  
County Baltimore

Village or City Coloma (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Robert Henry Tihen

07883 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH September 17, 1857  
(Month) (Day) (Year)

7 AGE 72 yrs. 9 mos. 27 ds. or LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Tihen

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Harman Matthews

(Address) Coloma, Ind.

15 Filed 7-15 1930 John W. Nottingham Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 7, 1930 to July 14, 1930, that I last saw him alive on \_\_\_\_\_, 1930.

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH was as follows:

Acute Pharyngitis

Contributory Secondary Acute myocarditis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.

(Signed) Ernest Hartman M. D.  
July 14, 1930 (Address) Chity Ford Rd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Nottingham Ind. DATE OF BURIAL July 17, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun Ind.

Permit issued 7-15-1930



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(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VICENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital St. Ward)

2 FULL NAME Clarence Alexander

07884  
(185)  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept 7, 1884  
(Month) (Day) (Year)

7 AGE 44 yrs. 9 mos. 9 ds. or min.? If LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Painter  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER James P. Alexander

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara Sullivan

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Alexander  
(Address) Elkton Md

15 Filed July 19, 1920 J. Frank Traeger Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 7/17, 1920  
that I last saw him alive on 7/17, 1920

and that death occurred on the date stated above, at 104 A. M.

The CAUSE OF DEATH \* was as follows:

From information  
Fractured Skull  
Fell from porch roof  
Accidental  
Contributory Secondary (Duration) yrs. mos. ds.

(Signed) \_\_\_\_\_ M. D.

1920 (Address) \_\_\_\_\_  
\*State the Disease Causing Death, or, in deaths from Violent Causes, State the Means of Injury and Whether Accidental, Suicidal or Homicidal. Green (Coroner)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Elkton Md

19 PLACE OF BURIAL OR REMOVAL Elkton Catholic Cemetery DATE OF BURIAL July 21, 1920

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Becil

04137

(9)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

Village or City Rising Sun (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Ruth Alexander

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH July 27th, 1929  
(Month) (Day) (Year)

7 AGE 8 yrs. 17 mos. 17 ds. or 17 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Norman Clyde Alexander

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Helen Burkins

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Clyde Alexander  
(Address) Rising Sun M.D.

15 Filed Apr 15 1930  
James M. Montgomery Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4-11, 1930 to 4-13, 1930, that I last saw him alive on 4-13, 1930

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:  
Coronary  
myocardial  
infarction  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Alfred D. ... M.D.  
4-14 1930 (Address) Rising Sun Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Brookview Md, DATE OF BURIAL April 16 1930

20 UNDERTAKER J.E. Tyson ADDRESS Rising Sun Md,

If more blanks are needed, address State Registrar, 16 W. Seneca St., Balto., Requesting V. S. No. 1.

Permit issued April 15 1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 1915  
BUREAU OF VITAL STATISTICS



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

13684

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Susie Alberta Alexander

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH <u>Nov 14</u> , 19 <u>30</u> (Month) (Day) (Year)
---

7 AGE <u>6</u> yrs. <u>—</u> mos. <u>1</u> ds. or <u>—</u> min.?	If LESS than 1 day ____ hrs.
---	------------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer)
---

9 BIRTHPLACE (State or country) md10 NAME OF FATHER David W Alexander11 BIRTHPLACE OF FATHER (State or country) md12 MAIDEN NAME OF MOTHER Sharp13 BIRTHPLACE OF MOTHER (State or Country) Quinn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David W Alexander  
(Address) North East md15 Filed 11/18/30 1930 Geo W. Decker  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 15, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 13 1930 to Nov 15, 1930  
that I last saw her alive on Nov 15, 1930  
and that death occurred on the date stated above, at 245P m.  
The CAUSE OF DEATH \* was as follows:Pneumonia

Contributory Secondary

(Signed) [Signature] M. D.  
Nov 16 1930 (Address) North East md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, it not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL North East M.C. Cemetery DATE OF BURIAL Nov 18, 193020 UNDERTAKER Joseph R. Hunt ADDRESS North East md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired) 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intermittent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retcher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a final answer given in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

BUREAU

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City U.S. Veterans' Hospital, Perry Point, Md.

2 FULL NAME APPLEGET, Harold XC-1 053 053

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH October 7, 1893  
(Month) (Day) (Year)

7 AGE 37 yrs. 0 mos. 25 ds. or LESS than 1 day hrs. min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry, business, or establishment in which employed or (employer) ---

9 BIRTHPLACE (State or country) Cranbury, N. J.

10 NAME OF FATHER Sidney Q. Appleget

11 BIRTHPLACE OF FATHER (State or country) Cranbury, N. J.

12 M maiden NAME OF MOTHER Mary Dey

13 BIRTHPLACE OF MOTHER (State or Country) Cranbury, N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Perry Point, Md.

15 Filed Nov 3 1930 Charles W. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 2, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 15, 1930 to November 2, 1930.

that I last saw him alive on November 2, 1930.

and that death occurred on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH \* was as follows:

1. Tuberculosis, Pulmonary, chronic, advanced active, Type. C. 2. Spontaneous Pneumothorax, left.

(Duration) #1. 3 yrs. 2.2 days

Contributory Secondary Type. Dementia Praecox, Paranoid

(Duration) Approximately 4 yrs.

(Signed) F. E. Leslie Med. Officer in Charge, M. D.  
Nov. 3, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 18 yrs. 18 mos. 18 ds. In the State Unknown

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 918 Paterson Ave., E. Rutherford, N. J.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Undertaker: Oliver Bair, Nov. 5, 1930.  
1820 Chestnut St., Phila., Pa.

20 UNDERTAKER ADDRESS  
R. Madison Mitchell, LaVerre de Grace, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting Form 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

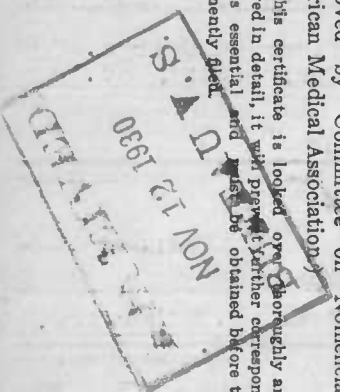
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iatrition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked upon thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No.     )

2 FULL NAME Arhatin

10284

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH Sept 17, 1930  
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Chesapeake City, Md.

10 NAME OF FATHER Harry A. McKim

11 BIRTHPLACE OF FATHER (State or country) Galacia

12 MAIDEN NAME OF MOTHER Mary Mankin

13 BIRTHPLACE OF MOTHER (State or Country) Galacia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. D. Howard  
(Address) Chesapeake City, Md.

15 Filed Sept. 17, 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h \_\_\_\_ alive on \_\_\_\_ 192

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Stillborn  
Cause unknown

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) C. D. Howard, M. D.

192 (Address) Chesapeake City

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Calver Cemetery Sept 17, 1930

20 UNDERTAKER ADDRESS

H. W. Phipps Chesapeake City, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At School*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 3 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u> Village or City <u>Near Fair Hill</u> (No. _____)		STATE OF MARYLAND CERTIFICATE OF DEATH 93 Registration Dist. No. <u>92</u>	
2 FULL NAME <u>William J. Armstrong</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write in words) <u>Married</u>	16 DATE OF DEATH <u>Dec 24</u> , 19 <u>30</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>Feb 12</u> , 18 <u>77</u> (Month) (Day) (Year)	7 AGE <u>53</u> yrs. <u>10</u> mos. <u>12</u> ds. or ____ min.?	17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>1924</u> , 19 <u>30</u> that I last saw him <u>live</u> on <u>1924</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>2:15</u> p.m. The CAUSE OF DEATH * was as follows: <u>From information</u> <u>Acute dilatation of the heart.</u> Contributory _____ Secondary _____ (Duration) ____ yrs. ____ mos. ____ ds. (Signed) _____ M. D.	
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	9 BIRTHPLACE (State or country) <u>Del.</u>		
PARENTS	10 NAME OF FATHER <u>J. P. Armstrong</u>	12 MAIDEN NAME OF MOTHER <u>Mary Armstrong</u>	
	11 BIRTHPLACE OF FATHER <u>Md.</u>	13 BIRTHPLACE OF MOTHER <u>Md.</u>	
	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>Mrs. Mary P. Armstrong</u> (Informant) <u>Charles M. B. Sharp</u> (Address) <u>Dec 27</u> , 19 <u>30</u> 15 Filed <u>Dec 27</u> , 19 <u>30</u> <u>Frank Trager</u> Registrar		
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____		19 PLACE OF BURIAL OR REMOVAL <u>Sharp Cemetery</u> DATE OF BURIAL <u>Dec 27</u> , 19 <u>30</u>	
20 UNDERTAKER <u>A. J. Alchemathy</u>		ADDRESS <u>Exton, Ind.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 7 1931  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

2 FULL NAME

07885

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

Mar 22, 189  
(Month) (Day) (Year)

7 AGE

71 yrs. 4 mos. — ds. or — min.

8 OCCUPATION

 (a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)
Retired

9 BIRTHPLACE (State or country)

Delaware

10 NAME OF FATHER

John George Ash

11 BIRTHPLACE OF FATHER (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Mary Ott

13 BIRTHPLACE OF MOTHER (State or Country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

July 27 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1930  
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from April 15 1930 to July 21 1930 that I last saw him alive on July 21 1930

 and that death occurred on the date stated above, at 6:15 p. m. The CAUSE OF DEATH \* was as follows:
Coronary Occlusion

Contributory Secondary

 (Duration) 1 yrs. 6 mos. 1 ds.  
 (Signed) James P. Plummer M. D.  
 192— (Address) 210 E. 2nd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cott Chapel Cemetery July 24, 1930

20 UNDERTAKER

ADDRESS

G. J. Ahern Cotton

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

02808

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95Village or City Colora, (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME J. Hester A. Atkinson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb 20, 1882  
(Month) (Day) (Year)

7 AGE 78 yrs. 1 mos. 14 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Wm. Rambo.

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mae A. Love  
(Address) Colora, Ind.

15 3-10-30 1930  
James M. Whittington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 10 - 1929 to March 8, 1930.

that I last saw him alive on March 5, 1930.

and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH \* was as follows:

Organic heart disease

(Duration) about 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. B. Shien M. D.

March 9, 1930 (Address) Residence

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Ind. DATE OF BURIAL

Rose Bank Cemetery Mar 11, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Ind.

Order received 8-10-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930

BUR

## PLACE OF DEATH

County

Cecil

13688

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

90

Village or City

Cecilton

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Cecilia Emory Bagley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

July 10, 1930  
(Month) (Day) (Year)

7 AGE

3 yrs. 3 mos. 29 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

Baby

9 BIRTHPLACE

(State or country)

Cecilton

10 NAME OF  
FATHER

Edward Bagley

11 BIRTHPLACE  
OF FATHER

(State or country)

Earleville Md

12 MAIDEN NAME  
OF MOTHER

Mary Emory

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Earleville Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Parents  
Cecilton Md.

15

Filed Nov. 8, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 8, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on Nov 5, 1930

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH \* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Catherine Gooden M.D.  
Nov 8, 1930 (Address) Cecilton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cecilton Cemetery

Nov 9, 1930

20 UNDERTAKER

ADDRESS

John J. Coffey

Cecilton Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Puglist, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Miller," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only, (not paid householders who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal," "Puerperal," "Puerperal," etc. State cause for which surgical operation was undertaken. For *PERMANENT DEATHS* state *CAUSE OF DEATH* and quality as *ACUTE, CHRONIC, SILENT, or NONFATAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data its essential and must be obtained before the certificate is permanently filed.

DEC 3 1930

WRITE FULLY,

WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County CecilVillage or City Elkton (No. \_\_\_\_\_)2 FULL NAME Bailey
 12323  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH
Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX M. 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
 (Write the word)

 6 DATE OF BIRTH October 12, 1930  
 (Month) (Day) (Year)

 7 AGE px mature If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
about 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.

## OCCUPATION

(a) Trade, profession or particular kind of work not none

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil County, Md.10 NAME OF FATHER James Bailey11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Lillian Poore13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Bailey(Address) Elkton15 Filed Oct 16 1930 J. Frank Zayer Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH October 12, 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from October 14, 1930 to October 14, 1930.
that I last saw him 7 days alive on October 14, 1930.and that death occurred on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH \* was as follows:

Premature Birth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Just J. [Signature] M. D.100-0-100 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Parents

DATE OF BURIAL

Oct 12, 1930

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

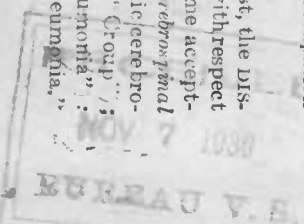
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, then primary affection with respect to time & relation, using always the same accepted term for the same disease. Examples: *Cerebrovascular fever (the only definite sign) is epidemic cerebrospinal meningitis; Diphtheria avoid use of "Croup"; Typhoid fever (never report "Typhoid Pneumonia"); Laborer overcome by bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rawlter wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			09113		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(31)		Registration Dist. No. <u>96</u>	
Village or City <u>Berryville</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Edith L. Baker</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the year)				
6 DATE OF BIRTH <u>April 15, 1891</u> (Month) (Day) (Year)						
7 AGE <u>39</u> yrs. <u>3</u> mos. <u>17</u> ds. or min. If LESS than 1 day, hrs.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>md</u>						
PARENTS	10 NAME OF FATHER <u>Samuel Smith</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>					
	12 MAIDEN NAME OF MOTHER <u>Emma Morgan</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Arthur Baker</u>						
(Address) <u>Berryville, md.</u>						
15 File <u>Aug 2 1930</u> <u>H. F. Sanders</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Aug 1, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 1, 1929</u> to <u>Aug 1, 1930</u> that I last saw him alive on <u>Aug 1, 1930</u> and that death occurred on the date stated above, at <u>Cecil</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>1</u> yrs. <u>2</u> mos. <u>17</u> ds. Contributory <u>Cachexia</u> Secondary (Duration) <u>1</u> yrs. <u>2</u> mos. <u>17</u> ds. (Signed) <u>Charles J. Foley</u> M. D. <u>8/2 1930</u> (Address) <u>Berryville, Md.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>2</u> mos. <u>17</u> ds. In the State <u>1</u> yrs. <u>2</u> mos. <u>17</u> ds. Where was disease contracted, if not at place of death? Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Cemetery Cecil</u>				DATE OF BURIAL <u>Aug 3, 1930</u>		
20 UNDERTAKER <u>Lee C. Pittman</u>				ADDRESS <u>Berryville</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbide; Revolver wound of head—homicide; Poisoned by acetic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 4 1930

BUREAU V. S.

WRITE

FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Ceil

04138

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs Rachel Barber

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Dec 4, 1845  
(Month) (Day) (Year)

7 AGE

84 yrs. 2 mos. 3 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Delaware

10 NAME OF  
FATHER

Wm Poore

11 BIRTHPLACE  
OF FATHER  
(State or country)

Delaware

12 MAIDEN NAME  
OF MOTHER

No Information

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

No Information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Wm Boyant

(Address)

Elkton, Md.

15

Filed

Apr 10

1920

H. J. Fausch, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 9, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
March 14, 1920, to April 7, 1920.

that I last saw her alive on April 7, 1920.

and that death occurred on the date stated above, at 11:55 pm.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage.

(Duration) yrs. mos. 7 ds.

Contributory  
Secondary

Anterior Sclerosis

(Duration) yrs. mos. ds.

(Signed) V. H. Mc Knight M. D.

April 8, 1920 (Address) Elkton, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Apr 10, 1920

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Puglistin, Compositor, Archibiel, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know: (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coreinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 7 1930

BUREAU



WRITE IN INK ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF

FATHER

11 BIRTHPLACE

OF FATHER

(State or country)

12 MAIDEN NAME

OF MOTHER

13 BIRTHPLACE

OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

Signed)

10/30

1930

(Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. B.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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'PLACE OF DEATH'

County

Village or City

(No.)

2 FULL NAME

12325

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day.....hrs.  
.....yrs. ....mos. ....7 ds. or.....min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from  
Oct. 11, 1930, to Oct. 18, 1930,

that I last saw him alive on Oct. 17, 1930,

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH \* was as follows:

Haemorrhage  
Umbilical CordContributory  
SecondaryNon closure of  
Umbilical Vein (Duration) .....yrs. ....mos. ....ds.(Signed) Oct. 18<sup>th</sup> 1930 (Address) J. F. Magraw M. D.\*State the Disease Causing Death, or if death from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rentier wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 5 1930

BUREAU

WRITE IN INK ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil

07886

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jester R. Bedwell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single6 DATE OF BIRTH Aug 2, 1928  
(Month) (Day) (Year)7 AGE 1 yrs. 11 mos. 10 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) md10 NAME OF FATHER Howard R. Bedwell11 BIRTHPLACE OF FATHER (State or country) md12 MAIDEN NAME OF MOTHER E. Eva Ferguson13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Eva Bedwell(Address) North East md15 Filed 7-15-30 1930 Geo. W. Queen  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 7, 1930, to July 12, 1930, that I last saw him alive on July 12, 1930,and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH \* was as follows:

Simple cerebral meningitisContributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.  
Secondary Broncho-pneumonia(Signed) A. A. Harrison M. D.  
July 14, 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M.C. Rm. July 15, 1930

20 UNDERTAKER ADDRESS

Joseph A. Shaw North East md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal Fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 8 1920  
BUREAU U. S.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. 3.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

02809

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 90Village or City Cecilston (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jefferson D. Beltz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

8 29 1865  
(Month) (Day) (Year)

7 AGE

67 yrs. 6 mos. 13 ds. or min.?

If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Wheelwright and

(b) General nature of industry, business, or establishment in which employed or (employer)

Hardware

9 BIRTHPLACE (State or country)

Penn.

10 NAME OF FATHER

Emanuel Beltz

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Ella Sarin

(Address)

Bowensend Del.

15

Filed 3/17 19301930J. B. Roman

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar. 14 1930.

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb. 28 1930. to Mar. 14 1930.that I last saw him alive on Mar. 14 1930.and that death occurred on the date stated above, at 7 P.m.

The CAUSE OF DEATH was as follows:

MyocarditisContributory  
Secondary(Duration) Indefinite yrs. mos. ds.Acute dilatation of heart(Signed) Geo. J. Jones M. D.Mar. 15 1930. (Address) Gulien Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cecilston Cemetery

DATE OF BURIAL

Mar. 17 1930

20 UNDERTAKER

John H. Cabbage

ADDRESS

Cecilston, Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus; *Farmer (retired 6- yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CalvertVillage or City Earlsville (No. \_\_\_\_\_)

## 2 FULL NAME

Felicia BiddleSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Feb 21 1930  
(Month) (Day) (Year)

7 AGE

6 yrs. 15 mos. 15 ds. or min.?If LESS than  
1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country)

Delaware  
Jessie Reed

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

Del

12 MAIDEN NAME OF MOTHER

Ethel Biddle

13 BIRTHPLACE OF MOTHER

(State or country)

Del

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ethel Biddle  
Earlsville Md

15

Filed

Sept 6 1930  
J. H. Loran  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 6 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 5 1930 to Sept 5 1930.that I last saw him alive on Sept 5 1930, and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH \* was as follows:

Gastro-Enteritis(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Sept 6 1930 (Address) Earlsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Church Cemetery Sept 8 1930

20 UNDERTAKER

ADDRESS

E. J. Daniel Towson Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Commissioner, Architect, Locomotive engineer, Civil engineer, Stationary engineer, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Country*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, the *always*, as the same accepted term for the same disease. Examples: (*Cerebrovascular fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOICIDE. As or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

BUREAU OF VITALS





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Solemon*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1920  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

PLACE OF DEATH  
County Cecil

Village or City North East (No. \_\_\_\_\_)

2 FULL NAME Infant Biddale

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH June 21, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day 6 hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Hazel Biddale

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Margie Sheppard

13 BIRTHPLACE OF MOTHER (State or Country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde Sheppard  
(Address) North East Md

15 Filed 6-21-30 1930 Geo W. Quess  
Registrar

06598

(161-9)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 21, 1930 to June 21, 1930, that I last saw him alive on June 21, 1930

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH \* was as follows:

Instrumental delivery with lacerations of brain

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) C. J. Staines M. D.  
June 21, 1930 (Address) North East, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East M. E. Cemetery DATE OF BURIAL June 21, 1930

20 UNDERTAKER Joseph P. Grant ADDRESS North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

Village or City

Elkton, Md.

(No.)

Chesapeake City Union Hospital

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Bigan

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

?

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

S

6 DATE OF BIRTH

November 12, 1930  
(Month) (Day) (Year)

7 AGE

4 Premature  
— yrs. 7/2 mos. — ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland.

10 NAME OF FATHER

Howard Biggs

11 BIRTHPLACE OF FATHER

(State or country)

Cecil County, Md.

12 MAIDEN NAME OF MOTHER

Vertude Woodall

13 BIRTHPLACE OF MOTHER

(State or Country)

Elkton, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Howard Biggs

(Address)

Chesapeake City, Md.

15

Filed

Nov 15 1930 J. Frank Jager Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 12, 1930 to Nov. 12, 1930  
that I last saw him alive on Nov. 12, 1930.and that death occurred on the date stated above, at 5:00 p.m.  
The CAUSE OF DEATH \* was as follows:

Premature Birth

(Duration) yrs. 2 mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. Frank Jager M. D.

192 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Barnes

Nov. 12, 1930

20 UNDERTAKER

ADDRESS

Parents



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not grudgingly employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUN

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County LeesvilleVillage or City Leesville (No. \_\_\_\_\_)

## 2 FULL NAME

Baby BirdSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	---

## 6 DATE OF BIRTH

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) 1

## 7 AGE

If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

none

## 9 BIRTHPLACE (State or country)

Maryland

## 10 NAME OF FATHER

Orin Bird

## 11 BIRTHPLACE OF FATHER (State or country)

Penn

## 12 MAIDEN NAME OF MOTHER

Emily Rebecca Hamilton

## 13 BIRTHPLACE OF MOTHER (State or Country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Orin Bird

(Address)

Leesville, Ind., 1925

## 15

Filed

Dec 17 1925  
DEC 17 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 1B DATE OF DEATH

Dec. 16<sup>th</sup>, 1930  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

## 17 I HEREBY CERTIFY, That I attended the deceased from

Dec. 16<sup>th</sup> 1930 to Dec. 16<sup>th</sup> 1930, that I last saw him alive on Dec. 16<sup>th</sup> 1930and that death occurred on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

DEC 17 1930

(Address)

Leesville, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 1B LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Cherry Hill Cemetery

\_\_\_\_\_, 19\_\_\_\_

## 20 UNDERTAKER

## ADDRESS

A. J. O'ConnorLeesville, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Intuition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 7 1931  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day \_\_\_\_ hrs.

\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

04139

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward)

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *Name*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asihenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 7 1930  
BUREAU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N B.--Every item of information should be carefully supplied. ACE should be stated. FACTS should be stated. CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

12326

(1592)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 90

Village or City near Cecilton (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Stanley Blanchfield

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 21, 1930  
(Month) (Day) (Year)

7 AGE 2 yrs. 25 mos. 25 ds. or LESS than 1 day hrs. min.?

### OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil Co. Md.

10 NAME OF FATHER Sam'l Thos. Blanchfield

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret A. Green

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam'l T. Blanchfield  
(Address) Cecilton Md.

15 Filed Oct. 17, 1930 J. H. Rowan  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 10, 1930 to Oct 16, 1930.

that I last saw him alive on Oct 15, 1930 and that death occurred on the date stated above, at 12 noon m.

The CAUSE OF DEATH \* was as follows:

Improper closure of  
prosin orals (Congenital)  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
Signed W. H. Bates M. D.  
19/16 1930 (Address) Eleton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cecilton Cemetery

Oct. 17, 1930

20 UNDERTAKER

ADDRESS

John H. Caffrey Cecilton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*; *Whooping cough*; *Chronic nodular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A. the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930  
BUREAU V. B.

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County PaulVillage or City Elkton (No. \_\_\_\_\_)

0321

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marion Blanchfield

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) 5

6 DATE OF BIRTH June 16, 1920  
(Month) (Day) (Year)

7 AGE Prenatal If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

Elkton Md

## 10 NAME OF FATHER

William

## 11 BIRTHPLACE OF FATHER (State or country)

Md

## 12 MAIDEN NAME OF MOTHER

May Blanchfield

## 13 BIRTHPLACE OF MOTHER (State or Country)

Acrapuke Co

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May Blanchfield(Address) Elkton

15 Filed Feb 16 1920 J. F. Fink  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 16, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 16, 1920 to Jan 16, 1920, that I last saw he alive on Jan 16, 1920, and that death occurred on the date stated above, at 11:24 a.m. The CAUSE OF DEATH \* was as follows:

Prenatal  
Birth  
This was a stillbirth (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## Contributory Secondary

(Signed) John J. Fink M. D.  
\_\_\_\_\_, 1920 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day.....hrs. 1 day.....hrs. 2 yrs.....mos. 2 ds. or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Nov. 6 1930

L. F. Sanders

Registrar

13687

(31)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 46

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November (Month) 5 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 30, 1930 to Nov-4, 1930

that I last saw him alive on Nov-4, 1930

and that death occurred on the date stated above, at 1 A. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis (Duration) 4 yrs.....mos.....ds.

Contributory Secondary

(Signed) C. J. Patterson M. D.

11/5 1930 (Address) Port Deposit, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westportingham Nov. 7, 1930

20 UNDERTAKER

ADDRESS

Lee A. Patterson Perryville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scranan, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. ACE should be stated. ACTUALLY PHYSICIAN'S should be stated. CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Henry M Borland

05416  
74a  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Jan 7 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 4 mos. 2 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer (retired)  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Matthew Borland

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda A. Alexander

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilbur Borland  
(Address) Elkton, Md

15 Filed May 12 1930 Frank J. Jager Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1928 to May 9 1930.

that I last saw him alive on May 9 1930, and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 ds.  
Secondary Arterio sclerosis

(Signed) J. Herbert Bates M. D.  
5/10 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Sharps Cemetery

DATE OF BURIAL

May 12, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer*; or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman* (b) *Produce*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If the certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 8 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME BOROSKY, Martin XC-1 368 175

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>male</b>	4 COLOR OR RACE <b>white</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write this word) <b>Married</b>
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## 6 DATE OF BIRTH

**February 24, 1892**  
(Month) (Day) (Year)

## 7 AGE

**38 yrs. 10 mos. 5 ds.** or **LESS than 1 day** hrs. min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work.

**Coal miner**

(b) General nature of industry business, or establishment in which employed or (employer).

**-**

## 9 BIRTHPLACE (State or country)

**Poland**

## 10 NAME OF FATHER

**Joseph Borosky**

## 11 BIRTHPLACE OF FATHER (State or country)

**Poland**

## 12 MAIDEN NAME OF MOTHER

**Unknown**

## 13 BIRTHPLACE OF MOTHER (State or Country)

**Poland**

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Hospital Records**

(Address)

**Perry Point, Md.**

## 15

Filed 12/31/30 192-Charles D. Morrison Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

**December 29, 1930**

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from **April 18, 1930** to **December 29, 1930**.that I last saw him alive on **December 29, 1930**.and that death occurred on the date stated above, at **6:10 P. m.**

The CAUSE OF DEATH \* was as follows:

**General Paralysis of the Insane**Approximately (Duration) **8** yrs. **8** mos. **8** ds.Contributory  
Secondary(Duration) **8** yrs. **8** mos. **8** ds.(Signed) **W.A. Ellison, Acting Med. Officer in Ch.**  
**Dec. 30, 1930** (Address) **Perry Point, Md.**

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death **8** yrs. **11** mos. **11** ds. In the State **Unknown** yrs. **8** mos. **8** ds.Where was disease contracted, if not at place of death? **Unknown**Former or usual residence **R.F.D. #3, Irwin, Pa.**19 PLACE OF BURIAL OR REMOVAL  
**J. W. McCauley, Undertaker,**  
**West Newton, Pa.**

DATE OF BURIAL

**Jan. 2, 1931.**

## 20 UNDERTAKER

ADDRESS

**R. MADISON MITCHELL, Havre de Grace, Md.**

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 5 1931



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City North East R.D. (No.)2 FULL NAME Paul H. Bouchelle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Dec 1, 1925  
(Month) (Day) (Year)

7 AGE 5 yrs. 4 mos. 12 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER William K Bouchelle

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Mary S. Rogers

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William K. Bouchelle(Address) North East R.D. #1

15 Filed 4-15-30 1925 Eselle Owens  
Registrar

04140

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 12, 1930 to Apr 13, 1930, that I last saw him alive on Apr 13, 1930, and that death occurred on the date stated above, at 3 P. m. The CAUSE OF DEATH \* was as follows:

Robin Pneumonia

Contributory Secondary Influenza  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Arthur Pembell M. D. (Address) W. East Md

\*State the Cause of Death, or, in 'deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boulders Chapel Cemetery Apr 16, 1930

20 UNDERTAKER ADDRESS

Joseph R. Grant North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

01520

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 90Village or City Cecil (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William H. Boulden

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 3 5 1862  
(Month) (Day) (Year)

7 AGE 67 yrs. 11 mos. 13 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co., Md.

10 NAME OF FATHER Lambert D. Boulden

11 BIRTHPLACE OF FATHER (State or country) Cecil Co., Md.

12 MAIDEN NAME OF MOTHER Hannah W. Price

13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1(Address) Mrs. Ella B. Gifford  
Rising Sun, Md.

15 Filed \_\_\_\_\_ 192 \_\_\_\_\_ Registrar \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 22, 1930 to Feb. 17, 1930, that I last saw him alive on Feb. 17, 1930,

and that death occurred on the date stated above, at 11:50 P. M.  
The CAUSE OF DEATH \* was as follows:

Myocarditis.

Contributory (Duration) 1 yrs. 1 mos. 1 ds.  
Secondary Cerebral Hemiplegia -

(Signed) G. C. Jones M. D. Feb. 19, 1930 (Address) Baltimore, Md.

\*State the cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL 2/20/1930

20 UNDERTAKER John D. Coffage Cecil Co., Md. ADDRESS \_\_\_\_\_

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Puglist, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 8 1930  
BUREAU V. S.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

April 27, 1920, to April 27, 1920.

that I last saw her alive on April 27, 1920.

and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH was as follows:

Contributory  
Secondary

(Signed)

4/29, 1920 (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)At place  
of death

yrs. mos. da.

In the  
State,

yrs. mos. da.

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oxford, Pa. April 30, 1920

20 UNDERTAKER

ADDRESS

Lee A. Patterson Perryville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal condition, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc. when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental burning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (R comments on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Cecil

01521

(742)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

95

Village or City

W. Rising Sun

(No.)

St.:

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eliza Sykes Boyd.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

widowed

6 DATE OF BIRTH

4 23 1930  
(Month) (Day) (Year)

7 AGE

76 yrs. 9 mos. 22 ds. or min.?

If LESS than  
1 day... hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed or (employer)

Good

9 BIRTHPLACE  
(State or country)

Va

10 NAME OF FATHER

Levi Sykes

11 BIRTHPLACE OF FATHER

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Catherine Wallace

13 BIRTHPLACE OF MOTHER

(State or Country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B M Boyd

(Address)

Rising Sun Md

15

Filed

Feb 17 1930

Registrar

Permit issued 2-17-30

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

2 13 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

2-11 1930 to 2-13 1930

that I last saw him alive on 2-11 1930

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Cerebral

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

R. D. O'Leary M.D.

2-15 1930

(Address) Rising Sun Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hopewell Cem Feb 17 1930

20 UNDERTAKER

ADDRESS

McC. J. Smith Taylor Rising Sun Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement. It should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 5 1918  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

02810

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 98Village or City Resing Sun (No. R 1)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Tranmelle Shock Boyd

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
----------------------	-----------------------------	--

6 DATE OF BIRTH <u>Oct 8, 1861</u> (Month) (Day) (Year)
---

7 AGE <u>68 yrs. 6 mos. 3 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
--------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country) <u>Cecil Co.</u>
---

10 NAME OF FATHER <u>James A Boyd</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Cecil Co.</u>
--

12 MAIDEN NAME OF MOTHER <u>Margaret Shock</u>
---

13 BIRTHPLACE OF MOTHER (State or country) <u>Cecil Co.</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thaggie E Boyd(Address) Resing Sun R. 1

15	Filed <u>3-18</u> 19 <u>30</u>	Registrar <u>James M. Wright</u>
----	--------------------------------	----------------------------------

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>March 11, 1930</u> (Month) (Day) (Year)
---

17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 28</u> 19 <u>29</u> to <u>March 11</u> 19 <u>30</u> , that I last saw him alive on <u>March 11</u> 19 <u>30</u>
---

and that death occurred on the date stated above, at 3:30 p.m. The CAUSE OF DEATH \* was as follows:

Coronary  
out know how long  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory out know  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. B. Blue M. D.  
3/12 1930 (Address) Resing Sun

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.	In the State ____ yrs. ____ mos. ____ ds.
--	---

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Ebenezer Cemetery</u>	DATE OF BURIAL <u>Mar 14, 1930</u>
---	---------------------------------------

20 UNDERTAKER <u>F. E. Tyson</u>	ADDRESS <u>Resing Sun, Md.</u>
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If more blanks are needed, address State Registrar, 16 W. Saratoga St., Belts., Requesting V. S. No. 1.

Permit issued 3-20-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930

BUREAU



MARGIN RESERVED FOR BINDING

WRITE PERMANENT INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

10286

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City Berry Point (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Isabelle Boyd

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH April 28, 1859  
(Month) (Day) (Year)

7 AGE 71 yrs. 4 mos. 10 ds. or min. ? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Henry Whitebeck

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Margaret McMullen

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Boyd

(Address) Berry Point Ind

15 Filed 9/15 1930 L Sanders  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1st 1930 to Sept 14, 1930  
that I last saw her alive on Sept 13, 1930,

and that death occurred on the date stated above, at 79 m.

The CAUSE OF DEATH \* was as follows:

Acute Myocarditis  
(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Chronic Glomerulonephritis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 21 ds.  
(Signed) J. H. Magnum M. D.  
Sept 15 1930 (Address) Berry Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Holbrook Cem. DATE OF BURIAL Sept 16, 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Berry Point

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

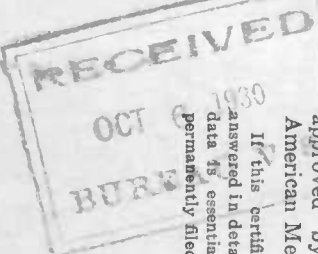
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicaemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Beech

04142

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

Village or City

Beech

(No. ....)

St. ....

Ward ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

George E. Boyer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb 5

(Month)

(Day)

1883

(Year)

7 AGE

47 yrs.

2 mos.

8 ds.

If LESS than

1 day .... hrs.

or .... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Chauffer

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

John Boyer

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Jane Tupper

13 BIRTHPLACE OF MOTHER (State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frisby Boyer

(Address)

Beech, Md

15 Filed

4/15 1930

J. C. Roman

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4

13

1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Apr 1

1930 to

Apr 13

1930

that I last saw him alive on Apr 10, 1930,

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory Secondary

Gastritis

(Duration) yrs. mos. ds.

(Signed) M. D.

Apr 14 1930 (Address) Beech -

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds.

In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Beech

DATE OF BURIAL

Apr 15, 1930

20 UNDERTAKER

Sarah B. Moore

ADDRESS

Middletown

253

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Paupster, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solemaker, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state, occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 8 1913  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit, Md. (No. 161-a)

2 FULL NAME Robert Hayes Boynes

02811  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 16

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 17, 1928  
(Month) (Day) (Year)

7 AGE 1 yrs. 2 mos. 20 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Charles Boynes

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Blanche Hortshorn

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Boynes  
(Address) Port Deposit, Md.

15 Filed 3/27 1930 L. H. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 4, 1930 to March 9, 1930  
that I last saw him live on March 9, 1930

and that death occurred on the date stated above, at 5 P. m.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

Contributory Secondary \_\_\_\_\_

(Signed) B. H. Harrison M. D.  
3/10/30 (Address) Port Deposit, Md.

\*State the Disease Causing Death, or, on deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Armadia Cem., Co. Pa. DATE OF BURIAL March 12, 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Port Deposit, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City  Rising Sun  (No. 742)

2 FULL NAME Howard F. Bradley

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 5, 1854  
(Month) (Day) (Year)

7 AGE 76 yrs. 2 mos. 8 ds. or min.?  
IF LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania Pa.

10 NAME OF FATHER Emmor Bradley

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania Pa.

12 MAIDEN NAME OF MOTHER Ruth Jones

13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adaline Bradley

(Address) Colore Md.

15 Filed July 8, 1930 Registrar John M. Mott

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 6, 1930 to July 8, 1930, that I last saw him alive on July 7, 1930, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH \* was as follows:  
Apoplexy

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. B. Blue M. D.

7/9/1930 (Address) Rising Sun

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pleasant Grove, Md. July 11, 1930

20 UNDERTAKER ADDRESS

J. E. Tyson Rising Sun, Md.

Permit saved 7-8-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City RD 1 (No. 100-01)

2 FULL NAME Helen Breza

01522 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Dec 11, 1929  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?  
yrs. 1 mos. 24 ds. or \_\_\_\_\_

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Michael Breza

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Katie Mykytyn

13 BIRTHPLACE OF MOTHER (State or Country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael Breza  
(Address) Chesapeake City, Md RD 1

15 Filed 4/6 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1-31-30, 192 to 2-4-30, 192,  
that I last saw him alive on 2-4-30, 192,

and that death occurred on the date stated above, at 7: a m.  
The CAUSE OF DEATH \* was as follows:

Bronchopneumonia

Contributory Secondary Nasal catarrh  
(Duration) yrs. mos. 2 ds.

(Signed) J. E. Van Norden M. D.  
192 (Address) Chesapeake City, Md

\*State the 1 is ase Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
St Rose Catholic Cemetery  
Chesapeake City Md

DATE OF BURIAL  
Feb 6, 1930

20 UNDERTAKER  
H. W. Pippin

ADDRESS  
Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1930  
BUREAU OF



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

05417

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton

(No. 1)

St. 1

Ward 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sara Agnes Bristow

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Jan 25, 1882

(Month)

(Day)

(Year)

7 AGE 48 yrs. 3 mos. 6 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) Maryland

PARENTS

10 NAME OF FATHER N. A. Van Burskirk

11 BIRTHPLACE OF FATHER

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucie E. Allen

13 BIRTHPLACE OF MOTHER

(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilmer Bristow

(Address) Chesapeake City

15 Filed May 3, 1930

By J. Frank Jones

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 10, 1930 to May 1, 1930

that I last saw her alive on May 1, 1930

and that death occurred on the date stated above, at 3:54 p.m.

The CAUSE OF DEATH \* was as follows:

Heart & Cholesterol Dilatation  
(Duration) 1 yrs. 1 mos. 1 ds.  
Contributory Chronic myocarditis  
Secondary

(Signed) Jacob H. Hume M. D.  
192 (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds.

In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery

DATE OF BURIAL May 4, 1930

20 UNDERTAKER H. W. Pippin

ADDRESS Elkton Md

# CERTIFICATE OF DEATH

U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on a first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fremen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Coburn pneumonia*; *Bronchopneumonia* ("Pneumonia,"**

unqualified, is indelinite), *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

2 FULL NAME Bristow

02112 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

6 DATE OF BIRTH Feb 2, 1930  
(Month) (Day) (Year)

7 AGE Pre-natal If LESS than 1 day 2 hrs. 5 yrs. 5 mos. 5 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Elkton, Md

10 NAME OF FATHER John Bristow

11 BIRTHPLACE OF FATHER (State or country) Chesapeake City

12 MAIDEN NAME OF MOTHER Anna Bollinger

13 BIRTHPLACE OF MOTHER (State or Country) Bristowtown, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Bristow  
(Address) Chesapeake City

15 Filed Feb 10 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 2, 1930 to Feb 2, 1930 that I last saw him alive on Feb 2, 1930 and that death occurred on the date stated above, at 7:30 p.m. The CAUSE OF DEATH \* was as follows:

Premature Birth  
(Duration) 5 yrs. 5 mos. 5 ds.

Contributory Secondary (Duration) 5 yrs. 5 mos. 5 ds.

(Signed) Garol B. Brown M. D.  
1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 4 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Blair

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Milled

10287  
(113)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 97

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH November 19, 1929  
(Month) (Day) (Year)

7 AGE 10 yrs. 16 mos. 16 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Elkton, Md.

10 NAME OF FATHER Taylor Brown

11 BIRTHPLACE OF FATHER (State or country) Cecil Co., Md.

12 MAIDEN NAME OF MOTHER Mollie Elizabeth Buchanan

13 BIRTHPLACE OF MOTHER (State or Country) Cecil Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Taylor Brown  
(Address) Elkton Md

15 Filed Oct 1, 1930 Frank Dyer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_\_\_ to \_\_\_\_\_ 192\_\_\_\_

that I last saw her alive on Sept. 29, 1930

and that death occurred on the date stated above, at 5.20 p.m.  
The CAUSE OF DEATH \* was as follows:

Dysentery and enteritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) T. St. Mc Knight M. D.  
9-29-30 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Johns DATE OF BURIAL Oct 7, 1930

20 UNDERTAKER A. G. Abernathy ADDRESS Elkton Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1934  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

06599

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

96

Village or City

Port Deposit

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Baby Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

col

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

June - 19, 1930

(Month)

(Day)

(Year)

7 AGE

Still Birth

If LESS than

1 day... hrs.

yrs.

mos.

ds.

or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Port Deposit, Md

10 NAME OF FATHER

Emmitt Brown

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Dorothy Attie Mc

13 BIRTHPLACE OF MOTHER

(State or Country)

Pocomoc City, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lulu Mc Muller

(Address)

Port Deposit Md

15 Filed

June 19, 1930 L. F. Sanders.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June - 19, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192... to 192...

that I last saw h. (m) alive on June 19, 1930

and that death occurred on the date stated above, at... m.

The CAUSE OF DEATH \* was as follows:

Still Birth -

Premature (7 1/2 mos) ds.

Contributory Secondary

(Signed) O. Benson M. D.  
of 19 1930 (Address) Port Deposit Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds.

In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

On Premises

DATE OF BURIAL

6/19, 1930

20 UNDERTAKER

Frather

ADDRESS

Port Deposit

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

04143  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Village or City Elkton (No. Union Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2 FULL NAME Not named Brown Registration Dist. No. 92

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>?</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>April 17</u> , 19 <u>30</u> (Month) (Day) (Year)		
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>0</u> min. If LESS than 1 day <u>0</u> hrs.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>None</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
PARENTS	10 NAME OF FATHER <u>Restus L Brown</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	
	12 MAIDEN NAME OF MOTHER <u>Lulu Jennings</u>	
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Restus Brown  
(Address) Elkton, Md

15 Filed April 19 1930 J. Frank Zayer  
Registrar

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>April 17</u> , 19 <u>30</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 17</u> 19 <u>30</u> to <u>April 17</u> , 19 <u>30</u> , that I last saw him alive on _____, 192____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows: <u>Premature birth at about 2 mos</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>G. T. Morrison</u> M. D. <u>April 18</u> 19 <u>30</u> (Address) <u>Elkton, Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____	
19 PLACE OF BURIAL OR REMOVAL <u>Hospital</u>	DATE OF BURIAL , 19____
20 UNDERTAKER	ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salemton*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1930  
BUREAU V. S.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			102 01523		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Beech</u>			Registration Dist. No. <u>92</u>			
Village or City <u>Elkton</u> (No. _____)			St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mrs George Bruce</u> <u>Sarah E. Bruce</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>Feb 12</u> , 18 <u>82</u> (Month) (Day) (Year)						
7 AGE <u>48</u> yrs. <u>0</u> mos. <u>13</u> ds. or _____ min.? If LESS than 1 day _____ hrs.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Md</u>						
PARENTS	10 NAME OF FATHER <u>Geo W. Lotman</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>					
	12 MAIDEN NAME OF MOTHER <u>Sarah Foraker</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Geo Bruce</u> (Address) <u>Elkton Md</u>						
15 Filed <u>Feb 25 1920</u> <u>J. Frank Jaxon</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Feb 25</u> , 19 <u>20</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 22</u> 19 <u>20</u> to <u>Feb 25</u> , 19 <u>20</u> that I last saw him alive on <u>Feb 23</u> , 19 <u>20</u> , and that death occurred on the date stated above, at <u>2 a</u> m. The CAUSE OF DEATH * was as follows: <u>Redding Angina</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>T. St. McKnight</u> M. D. <u>Feb 5 30</u> (Address) <u>Elkton Md</u>						
*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>North East County</u>						DATE OF BURIAL <u>Mar 1, 1920</u>
20 UNDERTAKER <u>R. T. Jones</u>						ADDRESS <u>Maryland</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection) with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 *ds*; *Bronchopneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		13689		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rising Sun Md.</u> (No. <u>Cherry</u> )		St. <u>Cherry</u> Ward <u>Cherry</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Augustus</u>		<u>Bramfield</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>			
6 DATE OF BIRTH <u>June</u> <u>Sixteenth</u> , 18 <u>86</u> (Month) (Day) (Year)					
7 AGE <u>94</u> yrs. <u>4</u> mos. <u>18</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Principio Md.</u>					
10 NAME OF FATHER <u>William Bramfield</u>					
11 BIRTHPLACE OF FATHER <u>Principio Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>Amelia Owens</u>					
13 BIRTHPLACE OF MOTHER <u>Principio Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George C. Bramfield</u> (Address) <u>Rising Sun Md</u>					
15 Filed <u>Nov. 4</u> 19 <u>30</u> <u>George C. Bramfield</u> Registrar					
16 DATE OF DEATH <u>October 20</u> , 19 <u>30</u> to <u>Nov 3</u> , 19 <u>30</u> that I last saw him alive on <u>Nov 2</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10</u> a.m. The CAUSE OF DEATH * was as follows: <u>Older Schwan</u>					
17 I HEREBY CERTIFY, That I attended the deceased from <u>October 20</u> , 19 <u>30</u> to <u>Nov 3</u> , 19 <u>30</u> , that I last saw him alive on <u>Nov 2</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10</u> a.m. The CAUSE OF DEATH * was as follows: <u>Older Schwan</u>					
Contributory Secondary (Duration) <u>1</u> yrs. <u>4</u> mos. <u>18</u> ds.					
(Signed) <u>J. B. Blue</u> M. D. <u>Nov 3</u> 19 <u>30</u> (Address) <u>Rising Sun Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>4</u> mos. <u>18</u> ds. In the State <u>1</u> yrs. <u>4</u> mos. <u>18</u> ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>West Nottingham</u>				DATE OF BURIAL <u>Nov 5</u> , 19 <u>30</u>	
20 UNDERTAKER <u>J. E. Tyson</u>				ADDRESS <u>Rising Sun Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (it is only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masks* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboxylic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, jaundice*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Registration Dist. No. 92

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			12327			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Near Chesapeake City, Po 1</u>			(90)			Registration Dist. No. <u>91</u>		
2 FULL NAME <u>Samuel Buckworth</u>			St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Never</u>	16 DATE OF DEATH <u>Oct. 1<sup>st</sup></u> , 19 <u>30</u> (Month) _____ (Day) _____ (Year) _____					
6 DATE OF BIRTH <u>Oct. 19<sup>th</sup></u> , 18 <u>51</u> (Month) _____ (Day) _____ (Year) _____			17 I HEREBY CERTIFY, That I attended the deceased from 192 <u>  </u> to 192 <u>  </u> , that I last saw him <u>dead</u> on <u>10/1</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:30 A.</u> m.					
7 AGE <u>78</u> yrs. <u>11</u> mos. <u>—</u> ds. or <u>—</u> min.?			The CAUSE OF DEATH * was as follows: <u>From information -</u> <u>Chronic Mitral</u> <u>Insufficiency</u> Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			(Signed) _____ M. D.					
9 BIRTHPLACE (State or country) <u>md</u>			192 <u>  </u> (Address) _____					
PARENTS	10 NAME OF FATHER <u>Charles Buckworth</u>		*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Heart Disease (Coroner)</u>					
	11 BIRTHPLACE OF FATHER <u>md</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
	12 MARRIAGE NAME OF MOTHER <u>Elizabeth Orr</u>		Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
13 BIRTHPLACE OF MOTHER <u>md</u>		19 PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery</u> DATE OF BURIAL <u>Oct 4</u> , 19 <u>30</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles Buckworth</u> (Address) <u>Middleton, Del</u>			20 UNDERTAKER <u>H. W. Pippin</u>			ADDRESS <u>Elkton Md</u>		
15 Filed <u>Oct. 4</u> , 19 <u>30</u> <u>B. Howard Beason</u> Registrar								

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 3 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Green

Village or City Childs (No. Union Hospital)

2 FULL NAME Bullock

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 1 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

6 DATE OF BIRTH April 22 - 1883  
(Month) (Day) (Year)

7 AGE Premature If LESS than 1 day hrs. 2 yrs. 2 mos. 2 ds. or min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Elkton, Md.

10 NAME OF FATHER George Bullock

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Mae Simpson

13 BIRTHPLACE OF MOTHER (State or country) Courtstown, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Bullock  
(Address) Elkton, Md.

15 Filed April 28 1923 J. Frank Jager Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 22 - 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 22 - 1923 to April 22 - 1923, that I last saw him alive on April 22 - 1923

and that death occurred on the date stated above, at 9:00 P. m. The CAUSE OF DEATH \* was as follows:

Premature Birth

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory  
Secondary

(Signed) J. Frank Jager M. D.  
1923 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Perkins

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 1 1930

BUREAU



WRITE

CORD

CORD

CORD

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1 PLACE OF DEATH

County

Village or City

(No.)

St. Ward

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

Registrar

14853

47

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at 11:50 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

12/4 1920 (Address) Ecklow Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beverly Green and Dec 7, 1920

20 UNDERTAKER

ADDRESS

Wm H Good Church Hill

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 7 1931

BUREAU V. S.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City White (No. 100)

2 FULL NAME Mrs Alice Birche

04145  
185  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Oct 27, 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 5 mos. 8 ds. or LESS than 1 day \_\_\_ hrs. \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Theodore Graham

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Caldwell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roberta J. Graham

(Address) Liberty Grove Ind.

15 Filed Apr 6 1930 J. E. Tyson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 28 1930 to April 4, 1930, that I last saw him alive on Apr 3, 1930,

and that death occurred on the date stated above, at 6:05 a.m. The CAUSE OF DEATH \* was as follows:

Inclusion of HF -  
residential Fall  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory Secondary Gastro Enteritis  
(Duration) \_\_\_ yrs. \_\_\_ mos. 10 ds.

(Signed) H. Allen C. E. E. M. D.  
Apr 4, 1930 (Address) West End

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. 3 mos. 2 ds. In the all life State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death? Putrefaction and

Former or usual residence Putrefaction, not

19 PLACE OF BURIAL OR REMOVAL West Nottingham Ind. DATE OF BURIAL April 7 1930

2D UNDERTAKER J. E. Tyson ADDRESS Rising Sun Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1930  
BUREAU

WRITE EARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			66600			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Near Warwick</u> (No. <u>183</u> )			St.: _____ Ward: _____			Registration Dist. No. <u>92</u>		
2 FULL NAME <u>Lloyd Burruss</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>June 7<sup>th</sup></u> , 19 <u>30</u> (Month) _____ (Day) _____ (Year) _____					
6 DATE OF BIRTH <u>April 10</u> , 19 <u>00</u> (Month) _____ (Day) _____ (Year) _____			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>6/7</u> , 19 <u>30</u> , that I last saw him <u>alive</u> on <u>6/7</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>11.45 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Gun-shot wounds of the head.</u> <u>Probably accidental.</u> (Duration) _____ yrs. _____ mos. _____ ds.					
7 AGE <u>30</u> yrs. <u>2</u> mos. <u>6</u> ds. or _____ min.?			If LESS than 1 day _____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory Secondary <u>Howard W. Green</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>6/7</u> 19 <u>30</u> (Address) <u>Elkton, Md.</u>					
9 BIRTHPLACE (State or country) <u>Va.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
PARENTS	10 NAME OF FATHER <u>J. H. Burruss</u>	11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>						
	12 MAIDEN NAME OF MOTHER <u>Ella Woolfolk</u>	13 BIRTHPLACE OF MOTHER (State or Country) <u>Va.</u>						
	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos Burruss</u> (Address) <u>Middleton Del</u>							
15 Filed <u>June 9</u> 19 <u>30</u> <u>Frank Burruss</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Chiles Potter Field</u>			DATE OF BURIAL <u>June 9</u> , 19 <u>30</u>		
			20 UNDERTAKER <u>H. W. Pippin</u>			ADDRESS <u>Elkton Md.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 8 1930  
BUREAU V S

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

2 FULL NAME

13690

(197)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day...hrs. or...min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Nov. 4

1930

Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 1<sup>st</sup>, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on 11/1/1930

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH \* was as follows:

Revolver wounds of chest

Contributory Secondary

(Signed) Howard W. Green

11/1/1930 (Address) Elkins, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Permitted 11/4/1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital) St. Union Hospital Ward Union Hospital

2 FULL NAME John Franklin Burton

05418 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Sept 20 1852  
(Month) (Day) (Year)

7 AGE 77 yrs. 8 mos. 12 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Farmer Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John W Burton

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Wolf

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Burton  
(Address) Elkton RD 5

15 Filed May 5 19230 Paul Trayer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 28 19230 to May 2, 19230

that I last saw him alive on May 1, 19230

and that death occurred on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Signed) O. J. Blain M. D.  
May 3, 19230 (Address) North East, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Union Cemetery

DATE OF BURIAL

May 5, 1930

20 UNDERTAKER

H. W. Propper

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
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## 1 PLACE OF DEATH

County CecilSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME BUSH, Paul L. XC-None

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Unknown</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH  
Unknown 1900  
(Month) (Day) (Year)7 AGE  
30 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Unknown  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Unknown10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1 Hospital Records(Address) Perry Point, Md.15 Filed 12/19/30 1930 Charles W. Morrison  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 18, 1930.  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from December 14, 1930 to December 18, 1930, that I last saw him alive on December 18, 1930, and that death occurred on the date stated above, at 1:55 P.m.

The CAUSE OF DEATH \* was as follows:

Psychosis with exhaustion, delerium,Contributory  
Secondary(Duration) Unknown yrs. 0 mos. 0 ds.  
(Signed) F. E. Leslie M. D.  
F. E. LESLIE, Medical Officer in Charge  
Dec. 19, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 4 da. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Dublin, Ga.

19 PLACE OF BURIAL OR REMOVAL

Adams Funeral Parlor, Dublin, Ga.

DATE OF BURIAL

Dec. 22, 1930

20 UNDERTAKER

R. Madison Mitchell, Havre de Grace, Md.

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

RECEIVED

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

U.S. Veterans' Hospital

Village or City Perry Point (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

Maryland St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME BYRD, Johnnie C. Char. 4337

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Apr 11 14, 1897  
 (Month) (Day) (Year)

7 AGE 33 yrs. 7 mos. 12 ds. or \_\_\_\_\_ min.?  
 If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
 (a) Trade, profession or particular kind of work Hotel clerk  
 (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Manners, North Carolina

10 NAME OF FATHER John A. Byrd

11 BIRTHPLACE OF FATHER (State or country) Harnett County, N.C.

12 MAIDEN NAME OF MOTHER Mary Henrietta Howard

13 BIRTHPLACE OF MOTHER (State or Country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Maryland

15 Filed Nov. 26 1923 Charles W. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 25, 19230  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 2, 19230 to Nov. 25, 19230, that I last saw him alive on Nov. 25, 19230,

and that death occurred on the date stated above, at 6:05 a.m.

The CAUSE OF DEATH \* was as follows:

Strangulation (suicide)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory Secondary Dementia praecox, hebephrenic type

(Signed) F. E. Leslie (Duration) 1 yrs. 1 mos. \_\_\_\_\_ ds.  
F. E. LESLIE, Med. Officer in Charge M. D.  
Nov. 26, 19230 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. 6 mos. 24 ds. In the State \_\_\_\_\_ yrs. 6 mos. 24 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Winston Salem, N.C.

19 PLACE OF BURIAL OR REMOVAL Urdetaker: Ben Parker  
Sanford, North Carolina DATE OF BURIAL Nov. 28, 1930

20 UNDERTAKER R. Madison Mitchell ADDRESS Havre de Grace Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			12328		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			60		Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. _____) St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
2 FULL NAME <u>Henry Stites Cameron</u>						
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		16 DATE OF DEATH <u>Oct 1</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>July 10</u> , 18 <u>57</u> (Month) (Day) (Year)				17 I HEREBY CERTIFY, That I attended the deceased from <u>May 21</u> , 19 <u>30</u> to <u>Oct 1</u> , 19 <u>30</u> , that I last saw him alive on <u>Oct 1</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>74</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic myocarditis</u>		
7 AGE <u>73</u> yrs. <u>3</u> mos. <u>21</u> ds. or min.?				18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Pulp mill</u>				Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Maryland</u>				(Signed) <u>John B. Bates</u> M. D. <u>1932</u> 19 <u>30</u> (Address) <u>Elkton Md</u>		
PARENTS	10 NAME OF FATHER <u>Stephen Cameron</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	12 MAIDEN NAME OF MOTHER <u>Mary Stites</u>			Where was disease contracted, if not at place of death? Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			19 PLACE OF BURIAL OR REMOVAL <u>Elkton Cemetery</u> DATE OF BURIAL <u>Oct 3</u> , 19 <u>30</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Henry Cameron</u> (Address) <u>Elkton Md</u>				20 UNDERTAKER <u>H. W. Phipps</u> ADDRESS <u>Elkton Md</u>		
15 Filed <u>Oct 3</u> 19 <u>30</u> <u>Frank J. Jager</u> Registrar						



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a full answer given in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME

Miscaminge Campbell

12329 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Un. 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 2, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Chesapeake City, Md.

10 NAME OF FATHER Homer L. Campbell

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna L. Hewlow

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. L. Campbell  
(Address) Ches. City, Md.

15 Filed 10/4 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on \_\_\_\_\_, 192

and that death occurred on the date stated above, at 7 a. m.  
The CAUSE OF DEATH \* was as follows:

Miscaminge  
1 1/2 mos. gestation

Contributory Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Herbert Hale M. D.  
10/2 1930 (Address) Severn Md.

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL on premises DATE OF BURIAL 10/2, 1930

20 UNDERTAKER Parents ADDRESS Ches. City, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, lœmans*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 3 1930

BUREAU U. S.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			13692 (161-E)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Near Middlebury, Md.</u>			St.: _____ Ward _____			Registration Dist. No. <u>90</u>		
2 FULL NAME <u>John Thomas Carroll</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>6</u>	16 DATE OF DEATH <u>11 12 1930</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>11 10 1930</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , 192					
7 AGE <u>Two days</u>			that I last saw him alive on _____, 192					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)			and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Sudden Hemorrhage</u> <u>Child died suddenly cause</u>					
9 BIRTHPLACE (State or country) <u>Md. Cecil</u>			Contributory Secondary (Duration) yrs. mos. ds.					
10 NAME OF FATHER <u>Theodore Carroll</u>			(Signed) <u>J. P. [Signature]</u> M. D.					
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			11/12/30 (Address) <u>Middlebury</u>					
12 MAIDEN NAME OF MOTHER <u>Foto Jones</u>			*State the cause of death, or, if death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ohio</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Theodore Carroll</u> (Address) <u>Middlebury, Md.</u>			Where was disease contracted, if not at place of death? Former or usual residence _____					
15 Filed <u>11-12-30</u> 19 <u>30</u> Registrar <u>J. H. [Signature]</u>			19 PLACE OF BURIAL OR REMOVAL <u>Templeville Md</u>			DATE OF BURIAL <u>11-13, 1930</u>		
			20 UNDERTAKER <u>Theodore Carroll</u>			ADDRESS <u>Middlebury</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Solemn*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 3 1930

PREPARED BY



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City North East Md (No. \_\_\_\_\_)

2 FULL NAME Betty L. Carter

10288

(159-e)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Aug 26, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 21 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER William R Carter

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Beatrice L. Lorrel

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William R Carter

(Address) North East Md

15 Filed 9/19/30 1920 Geo W. Carter Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 24, 19230 to Sept 18, 19230  
that I last saw him alive on Sept 18, 19230

and that death occurred on the date stated above, at 8 P. m.  
The CAUSE OF DEATH \* was as follows:

Spine Bifida  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_ Secondary \_\_\_\_\_

(Signed) H. A. Gindrey M. D.  
Sept 19, 19230 (Address) West Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M. C. County Sept 19, 19230

20 UNDERTAKER ADDRESS

Joseph R. Claus North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 16 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 2 1930  
BUR

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

05419

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91Village or City Chesapeake City (No. 129)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Charles Henry Carter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 5, 1862  
(Month) (Day) (Year)

7 AGE 67 yrs. 10 mos. 23 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Day Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Harry Carter

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER No information

13 BIRTHPLACE OF MOTHER (State or country) No information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Carter(Address) Chesapeake City, Md

15 Filed 5/31, 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21, 1930, to May 28, 1930.

that I last saw him alive on May 27, 1930.

and that death occurred on the date stated above, at 2a m.

The CAUSE OF DEATH \* was as follows:  
Chronic interstitial nephritis.

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Secondary Chronic myocarditis

(Signed) Herbert B. Bates M. D.  
5729 130 (Address) Section Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Augustine Cemetery

May 31, 1930

20 UNDERTAKER

ADDRESS

H. W. Pippin

Section Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary steamman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Kneelet wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930  
BUREAU OF

N B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u> Cecil </u>		0322		STATE OF MARYLAND CERTIFICATE OF DEATH <sup>93</sup>	
Village or City <u> Elk Mills </u> (No. _____)		St.: _____		Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u> Emma Maude Carter </u>		Registration Dist. No. <u> 92 </u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u> Female </u>	4 COLOR OR RACE <u> white </u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u> Married </u> (Write the word)			
6 DATE OF BIRTH <u> July 17 </u> , 18 <u> 83 </u> (Month) (Day) (Year)					
7 AGE <u> 46 </u> yrs. <u> 6 </u> mos. <u> 9 </u> ds. or min.? If LESS than 1 day ____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u> Housewife </u>					
9 BIRTHPLACE (State or country) <u> Maryland </u>					
10 NAME OF FATHER <u> Daniel Miller </u>					
11 BIRTHPLACE OF FATHER (State or country) <u> Ireland </u>					
12 MAIDEN NAME OF MOTHER <u> Margaret A. Cassidy </u>					
13 BIRTHPLACE OF MOTHER (State or country) <u> Ireland </u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u> Harry Carter </u> (Address) <u> Elk Mills, Md. </u>					
15 Filed <u> Jan 24 </u> , 192 <u> 0 </u> <u> Thomas Hayer </u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u> Jan 20 </u> , 19 <u> 30 </u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u> 192 </u> to <u> 192 </u> , that I last saw her <u> dead </u> alive on <u> 1/20 </u> , 19 <u> 30 </u> and that death occurred on the date stated above, at <u> 11 A. P. </u> m.					
The CAUSE OF DEATH * was as follows: <u> Acute Cardiac Dilatation </u> (Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u> J. H. Hayer M. D. </u> <u> Jan 24 </u> , 192 <u> 0 </u> (Address) <u> Eckstein, Md. </u>					
*State the Disease Causing Death, or, in deaths from Violent Cause, state the Means of Injury and (if whether Accidental, Suicidal or Homicidal). <u> Death from Heart Failure </u>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u> Cherry Hill Cemetery </u>				DATE OF BURIAL <u> Jan 24 </u> , 19 <u> 30 </u>	
20 UNDERTAKER <u> A. J. Ahern </u>				ADDRESS <u> Centon, Md. </u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationery firm, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Cecilton (No. 129)

2 FULL NAME Jacob F. Chamberlain

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 5 / 10 / 1857  
(Month) (Day) (Year)

7 AGE 79 yrs. 5 mos. 18 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Freeman Chamberlain  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie Biggs  
(Address) Cecilton Ind.

15 Filed 10-30 1930 J. F. Chamberlain  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 26, 1930 to Oct 28, 1930  
that I last saw him alive on Oct 27, 1930

and that death occurred on the date stated above, at 3 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis  
(Duration) 6 yrs. 6 mos. ds.

Contributory  
Secondary

(Signed) Dr. J. F. Chamberlain M. D.  
Oct 29, 1930 (Address) Salem Ind.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. ds. In the State 6 yrs. 6 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westminster Cemetery DATE OF BURIAL Oct 31, 1930

20 UNDERTAKER John F. Coffey ADDRESS Cecilton Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1900

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City Elkton (No. \_\_\_\_\_)2 FULL NAME Amy ChambersSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH June 17, 1846  
(Month) (Day) (Year)7 AGE 84 yrs. 6 mos. 10 ds. or min.? LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER David Lockard11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Rachel Pryor13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lang  
(Address) Elkton Md15 Filed Dec 30 1922 J. Frank Taylor Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 27, 1922  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 27, 1922 to Dec 27, 1922, that I last saw her alive on Dec 26, 1922,and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:Cerebral Apoplexy(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Byles M. D.  
127 1922 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery DATE OF BURIAL Dec 30, 192220 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

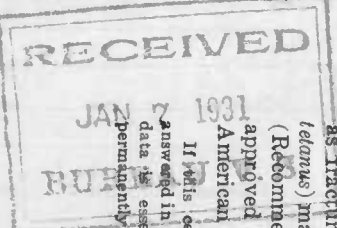
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; Bronchopneumonia (secondary), 10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

01524

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 93

Village or City Pleasant Hill No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Raymond W. Chidester

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 28, 1929  
(Month) (Day) (Year)

7 AGE 3 yrs. 5 mos. 5 ds. or 5 min. If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Clifford Chidester

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Violet Jones

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clifford Chidester  
(Address) Childs R. D# 1 m

15 Filed Feb 3 1930 C. S. Grant Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 10, 1929 to Feb 2, 1930, that I last saw him alive on Jan 25, 1930, and that death occurred on the date stated above, at 9 a. m. The CAUSE OF DEATH \* was as follows:

Whooping cough

(Duration) yrs. 1 mos. 23 ds.

Contributory Secondary measles

(Duration) yrs. 3 mos. 3 ds.

(Signed) Chas. F. Miller M. D.  
Feb 3, 1930 (Address) North East Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ In the State yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bay View M. P. Cemetery Feb 4, 1930

20 UNDERTAKER ADDRESS

Joseph R. Shaw North East Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dag laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housewife*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 8 1930  
BUREAU

WRITE

MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Kear Earleville (No. 91-2)

2 FULL NAME Bennyamin F. Chaffins

05420 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 9 6 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 6 mos. 24 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Sarah McKay

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bessie Seaman

(Address) Camden, N. J.

15 Filed 5/2 1930 J. H. Roman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_, 1930  
\_\_\_\_ (Month) \_\_\_\_ (Day) \_\_\_\_ (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 20 1930 to May 1 1930  
that I last saw him alive on Apr 30 1930,  
and that death occurred on the date stated above, at 5 a.m.  
The CAUSE OF DEATH \* was as follows:

Arterio-Sclerosis  
Insipiente (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Signed) Am. Bask M. D.  
\_\_\_\_ (Address) Beilton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Pauls Cemetery May 3, 1930

20 UNDERTAKER ADDRESS

John D. Caffery Beilton Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

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PLACE OF DEATH

County

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day hrs. or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH was as follows:

Acute Cardiac Failure

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

1920 (Address) Rising Sun Md

\*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, institutions, transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County  Cecil

Village or City  Elkton  (No. ....)

2 FULL NAME  Marian Virginia Clark

10289 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.  92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Female  4 COLOR OR RACE  White  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  Single

6 DATE OF BIRTH  March 9, 1920   
(Month) (Day) (Year)

7 AGE  10 yrs. 6 mos. 13 ds.  If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  at school   
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)  Maryland

10 NAME OF FATHER  John A Clark

11 BIRTHPLACE OF FATHER (State or country)  Maryland

12 MAIDEN NAME OF MOTHER  Cheta Danner

13 BIRTHPLACE OF MOTHER (State or Country)  Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  John A Clark   
(Address)  Elkton, Md

15 Filed  Sept 24 1930  J. Frank Danner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  September 22, 1930   
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  Sep 18 1930  to  Sep 22 1930 , that I last saw her alive on  Sep 21 1930 ,

and that death occurred on the date stated above, at  3:50 p.m.

The CAUSE OF DEATH \* was as follows:  
 Meningitis from accidental blow on head from a swinging door   
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos.  4  ds.

Contributory  Fracture of base of skull   
Secondary  in 1924  (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)  H. P. Morrison  M. D.  
 Sep 24 1930  (Address)  Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL  Elkton Cemetery  DATE OF BURIAL  Sep 24 1930

20 UNDERTAKER  H. W. Pippin  ADDRESS  Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worker! on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same adjective term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Coronary, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

09115

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day hrs. or 3 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY That I attended the deceased from 1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at F.C.M.

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed) M. D.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 6 1930



## PLACE OF DEATH

County  Cecil 

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No.  92 Village or City  Elkton  (No.  269   Rt. Main  St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME  William Jacob Clay 

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Male  4 COLOR OR RACE  White  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  married   
(Write the word)6 DATE OF BIRTH  January 6 - 1878   
(Month) (Day) (Year)7 AGE  52 yrs. 3 mos. 16 ds.  or min.?  
If LESS than 1 day hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work  Telegrapher and   
(b) General nature of industry business, or establishment in which employed or (employer)  Block operator 9 BIRTHPLACE (State or country)  Maryland 10 NAME OF FATHER  Joseph W. Clay 11 BIRTHPLACE OF FATHER (State or country)  Maryland 12 MAIDEN NAME OF MOTHER  Florence Jeffers 13 BIRTHPLACE OF MOTHER (State or Country)  Maryland 

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  Mrs Wm J. Clay (Address)  Elkton Md 15 Filed  April 4 1930   J. Hank Jones  Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  April 22, 1930   
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  Jan 12, 1930  to  April 22, 1930 .  
that I last saw him alive on  April 21, 1930 .  
and that death occurred on the date stated above, at  2:30 A.M. .  
The CAUSE OF DEATH \* was as follows: Uremic poisoning   
(Duration)  Three days  da.Contributory  Chronic Cardio-renal disease   
Secondary  arteriosclerosis  (Duration)  Indefinite  yrs. mos. ds.(Signed)  S. Burton Pearson  M. D.  
 Apr 22, 1930  (Address)  Newark Del. 

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  Elkton Cemetery  DATE OF BURIAL  Apr 25, 1930 20 UNDERTAKER  H. W. Pippin  ADDRESS  Elkton Md 

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# CERTIFICATE OF DEATH

Health Association.)

whatever, write None.

Lobar pneumonia, Bronchopneumonia ('Pneumonia,'

permanently filed.

American Medical Association.)

permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Union Hope (No. Elkton, Md.)

2 FULL NAME Baby Clifton MALE

09116  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 13, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. or \_\_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil

10 NAME OF FATHER Charles Edwin Clifton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Stevens

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E. Clifton (Father)  
(Address) Chesapeake City Md R.D.

15 Filed Aug 15 1930 J. Frank Jones  
(Registrar)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 13, 1930 to August 15, 1930, that I last saw him alive on August 15, 1930, and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH \* was as follows:

Failure of Circulation of Forebrain Artery  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_

(Signed) James J. Hissmald M. D.  
192 \_\_\_\_\_ (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Augustine Cemetery DATE OF BURIAL Aug. 16, 1930

20 UNDERTAKER Harvey G. Lane ADDRESS Chesapeake City Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tetanusaem, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Reisinger (No. 1012)

2 FULL NAME Minnie Belle Blinn

04147 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH January 28<sup>th</sup>, 1877  
(Month) (Day) (Year)

7 AGE 53 yrs. 2 mos. 28 ds. or min.?  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Joseph D. Snarely

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Prinella Grubb

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David S. Blinn  
(Address) Reisinger Maryland

15 Filed 4-7 1923  
James M. Worthington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 15 1923 to Apr 5 1923, that I last saw her alive on Apr 5 1923

and that death occurred on the date stated above, at 12 midnight

The CAUSE OF DEATH was as follows:

Acute Lobar pneumonia

Contributory Secondary Cording Exhaustion  
(Duration) yrs. mos. 5 ds.

(Signed) James M. Worthington M. D.  
Apr 6 1923 (Address) Liberty Proved

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Brookview Md. DATE OF BURIAL April 9, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Reisinger Md.

Permit issued 4-7-1930



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Coal engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 2 1930

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>96</u>	
Village or City <u>Berryville</u> (No. _____) St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Catherine Coburn</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>March 4</u> 19 <u>20</u> (Month) (Day) (Year)				
7 AGE <u>10</u> yrs. <u>9</u> mos. <u>27</u> ds. or min. <u>?</u> If LESS than 1 day ____ hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at school</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>md.</u>				
10 NAME OF FATHER <u>Harold E. Coburn</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>				
12 MAIDEN NAME OF MOTHER <u>Katherine Foley</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Catherine Coburn</u> (Address) <u>Berryville, md.</u>				
15 Filed <u>1/24</u> <u>1931</u> <u>J. J. Sanders</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Dec 31</u> 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 27</u> 19 <u>30</u> to <u>Dec 31</u> 19 <u>30</u> , that I last saw him alive on <u>Dec 31</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>2.30 p.</u> m.				
The CAUSE OF DEATH * was as follows: <u>Endocarditis Arthritis</u> <u>Pericarditis following</u> <u>Scarlatina</u> (Duration) ____ yrs. ____ mos. ____ ds.				
Contributory <u>Cardiac Failure</u> Secondary (Duration) ____ yrs. ____ mos. ____ ds.				
(Signed) <u>Charles J. Foley</u> M. D. <u>1/2</u> 19 <u>30</u> (Address) <u>St. James at Brainerd</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Mount Erin cem.</u> DATE OF BURIAL <u>Jan. 3</u> 19 <u>31</u>				
20 UNDERTAKER <u>Lee Patterson</u> ADDRESS <u>Berryville</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Loberer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 5 1901  
BUREAU

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

0323 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

Village or City Ebhtin (No. Union Hospital St.        Ward       ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Careo Colussio

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Italian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 25, 1 Unknown (Month) (Day) (Year)

7 AGE about 70 (If LESS than 1 day hrs. yrs. mos. ds. or min.?)

8 OCCUPATION (a) Trade, profession or particular kind of work Printer (b) General nature of industry, business, or establishment in which employed or (employer) 340 P.P.

9 BIRTHPLACE (State or country) Italy

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Italy

12 MAIDEN NAME OF MOTHER Werner

13 BIRTHPLACE OF MOTHER (State or Country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Caposelli

(Address) Severville, Md.

15 Filed Jan 20 1930 J. Frank Hayer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 17, 1930 to Jan 19, 1930. that I last saw him alive on Jan 17, 1930 and that death occurred on the date stated above, at 7:30 a.m. The CAUSE OF DEATH \* was as follows:

Intestinal Obstruction  
Suppurative  
(Duration) yrs. mos. ds.

Contributory Secondary Strangulated Hernia  
(Duration) yrs. mos. ds.

(Signed) H. Arthur C. C. M. D.  
Jan 19, 1930 (Address) West End, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Permyville Md.

Former or usual residence Permyville Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Catholic Cemetery, Md. Jan 22 1930

20 UNDERTAKER ADDRESS

Lee A. Patterson Severville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1930

BUR



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County CecilVillage or City North East (No. ....)2 FULL NAME John E. Conway

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)widower

6 DATE OF BIRTH

Mar 5, 1860  
(Month) (Day) (Year)

7 AGE

70 yrs. 9 mos. 25 ds.  
IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Labourer

(b) General nature of industry business, or establishment in which employed (or employer)

General9 BIRTHPLACE  
(State or country)md

10 NAME OF FATHER

William Conway11 BIRTHPLACE OF FATHER  
(State or country)md

12 MAIDEN NAME OF MOTHER

no information13 BIRTHPLACE OF MOTHER  
(State or Country)"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Conway(Address) North East, md

15

Filed 12-31-30 1931 Geo W. Owens  
Registrar

14857

(101-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 30, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 23, 1930 to Dec 30, 1930that I last saw him alive on Dec 30, 1930and that death occurred on the date stated above, at 6:5 P. m.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 7 ds.Contributory  
Secondary(Signed) C. H. Staring M. D.Dec 31, 1930 (Address) North East md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethelme Cemetery Jan 2, 1931

20 UNDERTAKER

ADDRESS

Joseph R. Hunt North East md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Book

0324 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH January 18, 1920  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. 2 mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Elkton Md

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Wynne Cook

13 BIRTHPLACE OF MOTHER (State or Country) Elkton Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wynne Cook  
(Address) Elkton Md

15 Filed \_\_\_\_\_ 192 \_\_\_\_\_ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 18, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 18, 1920 to Jan 18, 1920, that I last saw him live on Jan 18, 1920, and that death occurred on the date stated above, at 11:15 m. The CAUSE OF DEATH \* was as follows: Asphyxia

Contributory Secondary \_\_\_\_\_

(Signed) Justus J. [Signature] M. D.  
1920 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At School, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. \_\_\_\_\_)

2 FULL NAME Gachary Taylor Cooling

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Aug 5, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. 0 mos. 2 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Sea Captain retired  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm Cooling

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah A Ferris

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Cooling

(Address) Chesapeake City Md

15 Filed Aug 29 1930 B. Howard Brown  
Registrar

09117

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 25, 1930 to August 26, 1930

that I last saw him alive on August 26, 1930

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH was as follows:

Arteriosclerosis  
Myocarditis  
Chronic Nephritis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. S. Brown M. D.

1920 Chesapeake City Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Aug 29, 1930

20 UNDERTAKER W. W. Pippin ADDRESS Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

2 FULL NAME

02812

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

I HEREBY CERTIFY, That I attended the deceased from  
Mar 27 1923 to Mar 28 1923

that I last saw him alive on Mar. 28 1923

and that death occurred on the date stated above, at 4 P. M.  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary(Signed) C. H. Benson M. D.  
Mar 28 1923 (Address) Port Deposit Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. hausion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1930  
BUREAU V. S.

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1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

12/16

1920

Registrar

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the

State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil02813 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Isaac W. Cozlett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widower</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH  
Feb 24, 1855  
(Month) (Day) (Year)7 AGE  
75 yrs. 1 mos. 5 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Music Teacher  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country) Penna10 NAME OF FATHER Abraham Cozlett11 BIRTHPLACE OF FATHER  
(State or country) Wales British Isles12 MAIDEN NAME OF MOTHER Rachel Plauts13 BIRTHPLACE OF MOTHER  
(State or Country) Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isabel Cozlett(Address) North East Md15 Filed 4-1-30 1922 Geo. W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 29, 1930  
(Month) 7 (Day) 24 (Year) 193017 I HEREBY CERTIFY, That I attended the deceased from Mar 7, 1930, to Mar 29, 1930, that I last saw him alive on Mar 29, 1930.and that death occurred on the date stated above, at 10 30 P. ni.  
The CAUSE OF DEATH \* was as follows:Valvular Heart DiseaseContributory Secondary Uremia  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) A. A. Cozlett M. D.  
Apr 1, 1930 (Address) North East

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M. E. Cemetery Apr 1, 1930

20 UNDERTAKER ADDRESS

Joseph R. Shaw North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

L. P. Sanders,

Registrar

12331

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

10/15 1920 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the State

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 5 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union No.)

2 FULL NAME Armond Cox

06601

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Unknown  
(Month) (Day) (Year)

7 AGE 17 yrs. 17 mos. 17 ds. or 17 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1

(Address)

15 Filed June 30 1922 J. Frank Dayer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 6/29, 1920,  
that I last saw him dead alive, on 6/29, 1920.

and that death occurred on the date stated above, at 9A m.  
The CAUSE OF DEATH \* was as follows:

Fractured Skull

Auto accident  
(Duration) (yrs.) (mos.) (ds.)

Contributory  
Secondary

(Signed) Howard W. Dreyer (Duration) (yrs.) (mos.) (ds.)  
6/29/20 (Address) Elkton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death (yrs.) (mos.) (ds.) In the State (yrs.) (mos.) (ds.)

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Covington, Kentucky July 3, 1920

20 UNDERTAKER

ADDRESS

H. W. Pippin Elkton Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

Village or City Big Elk (No. \_\_\_\_\_)

2 FULL NAME Infant Crookham

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 4, 1930  
(Month) (Day) (Year)

7 AGE Still born If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

### 8 OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER John Crookham  
11 BIRTHPLACE OF FATHER md  
(State or country) Sophie Zinger  
12 MAIDEN NAME OF MOTHER Sophie Zinger  
13 BIRTHPLACE OF MOTHER Penn  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Crookham  
(Address) Calhoun, R.D. md

15 Filed June 4, 1930 C. S. Grant  
Registrar

06602

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 93

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6-4-1930  
Still Born (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Still Born, 192\_\_\_\_, that I last saw him alive on Still Born, 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_ m. The CAUSE OF DEATH \* was as follows:

Still Born  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) L. B. West M. D.  
6-4-1930 (Address) Calhoun, Del.

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cherry Hill M.C. DATE OF BURIAL June 4, 1930

20 UNDERTAKER C. S. Grant ADDRESS Calhoun md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## PARENTS

15 Filed Apr. 23, 1930 Registrar

(Informant) Mrs. James Culley  
(Address) Rising Sun, Md.

20 UNDERTAKER ADDRESS  
L. E. Tyson Rising Sun, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

11  
If more blanks are needed, address State Registrar  
Permit issued April 23-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 2 1920

BUREAU



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<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

02814  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

<sup>2</sup> FULL NAME Mayne Cully

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 27, 1929  
(Month) (Day) (Year)

7 AGE 9 yrs. 10 mos. 10 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER George S. Cully

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Mary E. Bryan

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George T. Cully  
(Address) North East Md

15 Filed Mar 11, 1930 Frank J. Jager  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 9<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 9<sup>th</sup>, 1930 to March 9<sup>th</sup>, 1930, that I last saw him alive on March 9<sup>th</sup>, 1930 and that death occurred on the date stated above, at 5:00 p.m. The CAUSE OF DEATH \* was as follows:

Pneumonia

Contributory Secondary

(Duration) 4 yrs. 4 mos. 4 ds.  
(Signed) Geo. T. Cully M. D.  
1929 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 9 yrs. 10 mos. 10 ds. In the State 9 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL North East M. E. County, Mar 12, 1930 DATE OF BURIAL

20 UNDERTAKER Joseph R. Shaw ADDRESS North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Frederick

07889

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City Terrapville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frank B. Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH April 20, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 2 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Welder  
(b) General nature of industry, business, or establishment in which employed or (employer) Stove Foundry

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert Cunningham

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Fisher

13 BIRTHPLACE OF MOTHER (State or Country) Vind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin B. Cunningham

(Address) Terrapville, Md.

15 Filed JUL 8 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 5, 1930 to July 5, 1930, that I last saw him alive on July 3, 1930

and that death occurred on the date stated above, at 2:30 P. m. The CAUSE OF DEATH \* was as follows:

Sarcoma of Intestines  
(Duration) \_\_\_\_ yrs. 3 mos. \_\_\_\_ ds.

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. J. Magraw M. D. July 7, 1930 (Address) Terrapville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cem DATE OF BURIAL July 8, 1930

20 UNDERTAKER See A. Patterson ADDRESS Terrapville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		04149		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Leecie</u>		(90)		Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u>		(No. <u>Union Hospital</u> )		St. _____ Ward _____	
2 FULL NAME <u>Alvin Norman Cummings</u>				(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>			
6 DATE OF BIRTH <u>April 30, 1887</u> (Month) (Day) (Year)					
7 AGE <u>42</u> yrs. <u>11</u> mos. <u>5</u> ds. or min. If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Cyford Pa</u>					
PARENTS	10 NAME OF FATHER <u>Alvin Cummings</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Leecie</u>				
	12 MAIDEN NAME OF MOTHER <u>Lydia Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alvin Cummings</u> (Address) <u>Elkton, Md.</u>					
15 Filed <u>Apr 5 - 1920</u> <u>John H. Fager</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 5th</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 1st</u> , 19 <u>30</u> to <u>April 5th</u> , 19 <u>30</u> , that I last saw him alive on <u>April 5th</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:30 A.</u> m. The CAUSE OF DEATH * was as follows: <u>Gangrene of scrotum.</u>					
Contributory (Duration) ____ yrs. ____ mos. ____ ds. <u>Chronic Myocarditis</u> Secondary (Duration) ____ yrs. ____ mos. ____ ds. <u>2</u>					
(Signed) <u>John H. Fager</u> M. D. <u>April 5 - 1930</u> (Address) <u>Elkton Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death _____ Former or usual residence <u>Elkton, Md.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Cyford Cemetery</u>				DATE OF BURIAL <u>April 8, 1930</u>	
20 UNDERTAKER <u>H. H. Piffin</u>				ADDRESS <u>Elkton Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

MAY 7 1930  
BUREAU OF

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

14859

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Eketon, R.D. 3

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Elizabeth J. Curry

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Aug

13

1865

(Month)

(Day)

(Year)

7 AGE

65

yrs.

4

mos.

6

ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Penn

10 NAME OF

FATHER

Christian Bezold

11 BIRTHPLACE

OF FATHER

(State or country)

Germany

12 MAIDEN NAME

OF MOTHER

Jeanette Greenwood

13 BIRTHPLACE

OF MOTHER

(State or Country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Curry

(Address)

Eketon, Md R 3

15

Filed

Dec 20

1920

J. Frank Traylor

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December

19

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

June 20

1920

to

Dec 19

1930

that I last saw her alive on Dec 19, 1930,

and that death occurred on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH \* was as follows:

Acute nephritis

(Duration)

yrs.

mos.

10 ds.

Contributory

Secondary

Carcinoma of

stomach

(Duration)

yrs.

mos.

18 ds.

(Signed)

Hessie M. Johnson

M. D.

Dec 19

1930

(Address)

Newark Del

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry Hill Cemetery

Dec. 23, 1930

20 UNDERTAKER

ADDRESS

A. S. Ahumachy

Eketon, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 7 1931

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE

FAMILY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

13694

(126)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Elkton

(No.)

Union Hospital St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Alphonso Daniels

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Aug 20<sup>th</sup> 1929

(Month)

(Day)

(Year)

7 AGE

1 yrs. 2 mos. 23 ds. or min.

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Cecil Co., Md.

10 NAME OF FATHER

Frank Daniels

11 BIRTHPLACE OF FATHER

Elkton, Md.

12 MAIDEN NAME OF MOTHER

Helen Washington

13 BIRTHPLACE OF MOTHER

Cecil Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Daniel

(Address)

Elkton Md.

15

Filed

Nov 15 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 13 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 9<sup>th</sup> 1930 to Nov 13<sup>th</sup> 1930

that I last saw him alive on Nov 13 1930

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Peritonitis

(Duration) yrs. mos. 4 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

V. H. McHugh M. D.

Nov 13 1930 (Address) Elkton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Colored Cemetery

DATE OF BURIAL

Nov 15 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia").

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DEC 5 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Near Earleville

2 FULL NAME William W. Daniels

06603

(1226)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St.:

Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

3 (Month) 17 (Day) 1891 (Year)

7 AGE

39 yrs. 2 mos. 29 ds. or min.?

If LESS than  
1 day hrs.  
min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Cecil Co. Ind.

10 NAME OF FATHER

William B. Daniels

11 BIRTHPLACE OF FATHER

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Mary L. Vansant

13 BIRTHPLACE OF MOTHER

(State or country)

Cecil Co. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary L. Daniels  
Earleville, Ind.

15

Filed

6/18 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6 (Month) 16 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov 1929 to June 16, 1930, that I last saw him alive on June 15, 1930,

and that death occurred on the date stated above, at 6 a.m. The CAUSE OF DEATH \* was as follows:

Embolism of Liver

(Duration) 2 yrs. 1 mos. 1 ds.

Contributory Secondary

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) A. M. Black M. D.

June 17, 1920 (Address) Cecil Co. Ind.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Pauls Cemetery June 18, 1930

20 UNDERTAKER

ADDRESS

John D. Haffage Cecil Co. Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Paysicist, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Perry Point No. Augustus

<sup>2</sup> FULL NAME James A. Davidson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 31, 1878  
(Month) (Day) (Year)

7 AGE 51 yrs. 9 mos. 14 ds. or IF LESS than 1 day. hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchant  
(b) General nature of industry business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Meade Davidson

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Wilts

13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A. Davidson Jr.  
(Address) 1106 3rd St. Perry Point

15 Filed 3/15 1930 L. J. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 14, 1930 to March 15, 1930, that I last saw him alive on March 15, 1930, and that death occurred on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH \* was as follows:

From information  
(suicide) carbolic acid.

Contributory from information  
Secondary (Duration) yrs. mos. ds.  
(Signed) Larimer Sanders Registrar  
3/17 1930 (Address) Perryville Md.

State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means of injury and (2) whether Accidental, Suicidal or Criminal. Carbolic acid

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Armville Va. DATE OF BURIAL March 1930

20 UNDERTAKER R. Madison Mitchell ADDRESS Navre de Grace Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archibut, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

0325

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

Village or City Elkton (No. MD 3)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John R Davidsson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug 12, 1840  
(Month) (Day) (Year)

7 AGE 89 yrs. 5 mos. 12 ds. or min. 2  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer (retired)  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER John Davidsson

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Mary A. Hendrickson

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John R. Davidsson  
(Address) Elkton Md RD 3

15 Filed Jan 25 1930 J. M. Hager Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1 1930 to Jan 24 1930,  
that I last saw him alive on Jan 23 1930,  
and that death occurred on the date stated above, at 12:10 P.M.  
The CAUSE OF DEATH \* was as follows:

Chronic myocarditis

(Duration) yrs. mos. 2 ds.

Contributory  
Secondary

(Signed) J. M. Hager M. D.  
192 (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Bethel Cemetery Md

DATE OF BURIAL

Jan 27, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton, Md



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answer  
data  
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II  
(me)

## 1 PLACE OF DEATH

County Cecil

U.S. Veterans' Hospital,

Village or City Perry Point, Md. (No. \_\_\_\_\_)2 FULL NAME George Davis C-299 803STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH May 18, 1887  
(Month) (Day) (Year)7 AGE 43 yrs. 0 mos. 8 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Patient(b) General nature of industry, business, or establishment in which employed or (employer) Perry Point Hospital9 BIRTHPLACE  
(State or country)Pennsylvania

## 10 NAME OF FATHER

U11 BIRTHPLACE OF FATHER  
(State or country)NK

## 12 MAIDEN NAME OF MOTHER

N13 BIRTHPLACE OF MOTHER  
(State or Country)N

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry Point Hospital Record(Address) Perry Point, Md.15 Filed May 26, 1930 Ed Charles W. Macdonald  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 26, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,  
that I last saw him dead on May 26, 1930and that death occurred on the date stated above, at 12:40 P.m.  
The CAUSE OF DEATH \* was as follows:Heart Failure from fatty degeneration and arteriosclerosis, occurring in swimming pool.Contributory Dementia Praecox, Catatonic  
(Duration) Unknown yrs. \_\_\_\_ mos. \_\_\_\_ ds.Type. Secondary (Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

May 26, 1930 (Address) Elkton, Md.\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  
Myocardial Infarction

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 8 mos. 1 ds. In the State Unknown yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted, Unknown  
if not at place of death?Former or usual residence 1018 Center St., Ashland, Pa.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Undertaker: Frank Burke, 718 Center St., Ashland, Pa. June 2, 1930

## 20 UNDERTAKER

## ADDRESS

Pennington & Son, Havre de Grace, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE MINUTELY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
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1 PLACE OF DEATH

County

Cecil

16290

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Near Entow

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Martha E. Davis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Feb 16, 1854

(Month)

(Day)

(Year)

7 AGE

72 yrs.

7 mos.

5 ds.

If LESS than  
1 day... hrs.  
or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Delaware

10 NAME OF FATHER

no record

11 BIRTHPLACE OF FATHER

(State or country)

no record

12 MAIDEN NAME OF MOTHER

no record

13 BIRTHPLACE OF MOTHER

(State or Country)

no record

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wesley C. Davis

(Address)

Newark Del.

15

Filed

Sept 24

1923

John H. Trager

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 9 - 1926 to Sept 21, 1930

that I last saw him alive on Sept 21, 1930

and that death occurred on the date stated above, at... m.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

John P. Downes M. D.  
Sept 23, 1930 (Address) Newark DE

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. mos. ds.

In the State 4 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Newark Del.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salem Del.

Sept 25, 1930

20 UNDERTAKER

ADDRESS

R. J. Davis

Newark

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinners* (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, delirium*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

2 FULL NAME Joseph Deak

09118 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH 9 12 1909  
(Month) (Day) (Year)

7 AGE 20 yrs. 11 mos. 9 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Hungary, Europe

10 NAME OF FATHER Joseph Deak

11 BIRTHPLACE OF FATHER (State or country) Hungary, Europe

12 MOTHER'S NAME OF MOTHER Bertha Chrusky

13 BIRTHPLACE OF MOTHER (State or Country) Hungary, Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Deak

(Address) Kearney, N.J.

15 Filed Aug 31 1920 J. H. Dwyer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 31, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 30 1920 to Aug 31, 1920.

that I last saw him alive on Aug 30, 1920,

and that death occurred on the date stated above, at 120 A.M.

The CAUSE OF DEATH \* was as follows:

Fractured skull  
Hemorrhage of brain.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory auto. accident  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Howard W. Green M.D.

8/31/1920 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Beth Ambroy N.J. DATE OF BURIAL Sept 2, 1920

20 UNDERTAKER Harry W. Pippin ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

2 FULL NAME Joseph Deak

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH 3 23 1911  
(Month) (Day) (Year)

7 AGE 19 yrs. 5 mos. 8 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) N. J.

10 NAME OF FATHER Stephen Deak

11 BIRTHPLACE OF FATHER (State or country) Hungary, Europe

12 MAIDEN NAME OF MOTHER Mary Jurek

13 BIRTHPLACE OF MOTHER (State or Country) Hungary, Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Deak  
(Address) Roachey, N. J.

15 Filed Aug 31 1923 John H. Gray  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 30 1930 to Aug 31, 1930, that I last saw him alive on Aug 31, 1930,

and that death occurred on the date stated above, at 12:50 p.m.  
The CAUSE OF DEATH \* was as follows:

Rupture of intestines  
Internal hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Automobile accident  
Secondary

(Signed) Howard W. Green  
8/31 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Beth Amboy N. J. Sept 2, 1930

20 UNDERTAKER ADDRESS  
Harry W. Pippin Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *Pertussis*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *pertussis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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PLACE OF DEATH,

County BaltimoreVillage or City Northeast (No. \_\_\_\_\_)2 FULL NAME Gertrude W. DeanSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH June 9, 1877  
(Month) (Day) (Year)

7 AGE 53 yrs. 7 mos. 23 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work At home

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

md

## 10 NAME OF FATHER

Wakeman Latchell

## 11 BIRTHPLACE OF FATHER

(State or country)

md

## 12 MAIDEN NAME OF MOTHER

Martha Baker

## 13 BIRTHPLACE OF MOTHER

(State or Country)

md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Dean  
North East Md

15

Filed 9-3-30 192Geo W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 1st, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1st 1920 to Sept 1st 1920, that I last saw her alive on Aug 31st 1920

and that death occurred on the date stated above, at 10:30 A.M.  
The CAUSE OF DEATH \* was as follows:

Chronic myocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## Contributory Secondary

Chronic Bronchitis (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) James J. H. H. H. M. D.192 \_\_\_\_ (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

North East M. C. Cemetery

## DATE OF BURIAL

Sept 4, 1920

## 20 UNDERTAKER

Joseph R. Houser

## ADDRESS

North East Md

If more blanks are needed, address State Registrar 12 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renalr wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 2 1920

BUREAU OF

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

13695

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. Union Hospital St.      Ward     ) (If death occurred in a hospital or institution, give its NAME, extend of street and number.)

2 FULL NAME Not named Dean

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)     

6 DATE OF BIRTH Nov. 24, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day 0 hrs. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. R. Dean

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Elizabeth Purnell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)       
(Address)     

15 Filed Nov 25 1930 J. Frank Baker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 24, 1930 to Nov 24, 1930, that I last saw him alive on, 192  ,

and that death occurred on the date stated above, at      m. The CAUSE OF DEATH \* was as follows: Premature birth

Contributory (Duration) yrs. mos. ds. Criminal abortion  
Secondary

(Signed) Ch. D. Morrison M. D.  
Nov 25 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Nov 25, 1930

20 UNDERTAKER Parents ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930  
BUREAU V. S.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

04150 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

192

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shoel," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 7 1930  
BUREAU V. S.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

PLACE OF DEATH

County

Cecil

01535

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Elkton

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Irwin H. Deibert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

July 2, 1864  
(Month) (Day) (Year)

7 AGE

65 yrs. 7 mos. 7 ds. or min.?

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

ship builder

9 BIRTHPLACE

(State or country)

Penn

10 NAME OF FATHER

Henry Deibert

11 BIRTHPLACE OF FATHER

(State or country)

Penn

12 MAIDEN NAME OF MOTHER

Sarah E. Heiser

13 BIRTHPLACE OF MOTHER

(State or Country)

Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Deibert

(Address)

Elkton, Md.

15

Filed

Feb 12 1930 J. Frank Taylor  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 9, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1926 to Feb 9, 1930

that I last saw him alive on

Feb 9, 1930

and that death occurred on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
(cardiac dilatation)

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Herbert Bales

M. D.

1930 (Address) Elkton Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

July 12, 1934

20 UNDERTAKER

H. W. Phipps

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 6 1930

BUREAU

PLACE OF DEATH

County

Cecil

01526

187-C

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Elkton

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Wilmer N. Deebest

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Sept 22<sup>nd</sup>, 1919

(Month)

(Day)

(Year)

7 AGE

10 yrs. 4 mos. 9 ds. or min.?

If LESS than

1 day hrs.

1 day hrs.

1 day hrs.

8 OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed or (employer)

Scholar

9 BIRTHPLACE

(State or country)

Md

10 NAME OF

FATHER

Walter N. Deebest

11 BIRTHPLACE

OF FATHER

(State or country)

Md

12 MAIDEN NAME

OF MOTHER

Emeliah Brown

13 BIRTHPLACE

OF MOTHER

(State or Country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Deebest

(Address)

Elkton, Md

15

Filed

Feb 4

1920

James H. Beyer

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 1, 1930, 192

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192

to

192

that I last saw him

dead

on

2/1, 1930

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH \* was as follows:

Fracture of skull  
Accidental fracture of automobile

(Duration)

yrs.

mos.

ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

H. C. Embrey

M. D.

192

(Address)

no and

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Feb 4, 1930

20 UNDERTAKER

H. W. Whipple

ADDRESS

Elkton 2nd

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 6 1930  
BUREAU OF VITAL STATISTICS  
U. S. DEPARTMENT OF COMMERCE

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1 PLACE OF DEATH  
County Cecil

04151  
WITHIN CORPORATE LIMITS OF

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Ecklow (No. 413 North St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Margaret Leibert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Apr 4 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ecklow Md

10 NAME OF FATHER C. Ellis Leibert

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth M. Lebergood

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Ellis Leibert

(Address) Ecklow Md

15 Filed Apr 5 1930 John H. Hager Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 4 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h. alive on 11 Apr 1930

and that death occurred on the date stated above, at 11 Am m.

The CAUSE OF DEATH \* was as follows:

4 mos. miscarriage  
still birth  
(Duration) 4 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 4 yrs. 0 mos. 0 ds.  
(Signed) Herbert Baker M. D.  
4/4 1930 (Address) Ecklow Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Premises

4/4 1930

20 UNDERTAKER

ADDRESS

Parents



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1920  
BUREAU V.S.

PLACE OF DEATH

County

Village or City

(No.)

FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

DEC 19 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 3:15 P.M.  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary

(Signed) M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1931  
BUREAU V. S.

WRITE PERMANENT, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			45		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Becil</u>					Registration Dist. No. <u>94</u>	
Village or City <u>North East, R.D.</u> (No. _____)			St.: _____		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Carl Deemes</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>				
6 DATE OF BIRTH <u>April 29, 1857</u> (Month) (Day) (Year)						
7 AGE <u>72 yrs. 11 mos. 25 ds.</u> or <u>min.?</u> If LESS than 1 day ____ hrs.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>						
10 NAME OF FATHER <u>Carl Deemes</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>France</u>						
12 MAIDEN NAME OF MOTHER <u>Georgiana McNamee</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry Deemes</u> (Address) <u>Reading Room, Md. R.D.</u>						
15 Filed <u>4-26-30</u> <u>Geo. W. Deemes</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 27, 1929</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 1929</u> to <u>Apr 24, 1929</u> , that I last saw him alive on <u>Apr 10, 1929</u> , and that death occurred on the date stated above, at <u>7 a.m.</u>						
The CAUSE OF DEATH * was as follows: <u>Coronary Artery</u> (Duration) <u>2</u> yrs. <u>mos.</u> <u>ds.</u> Contributory <u>Heart weakness</u> Secondary (Signed) <u>Walter C. Ambrose</u> M.D. <u>4-26-1930</u> (Address) <u>West End Rd.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>North East M. Cemetery</u>					DATE OF BURIAL <u>4-28-30</u>	
20 UNDERTAKER <u>J. J. Abernathy</u>					ADDRESS <u>Elkton, Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like data is essential and must be obtained before the certificate is permanently filed.

MAY 2 1907  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		16292		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u> (No. ....)		St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Russell E. Dennis</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write age and word) <u>Married</u>			
6 DATE OF BIRTH <u>March 2</u> , 189 <u>7</u> (Month) (Day) (Year)					
7 AGE <u>33</u> yrs. <u>6</u> mos. <u>4</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Ray</u>					
9 BIRTHPLACE (State or country) <u>Md.</u>					
10 NAME OF FATHER <u>Charles Dennis</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>					
12 MAIDEN NAME OF MOTHER <u>Mary E. Rhoades</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Canada</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edith E. Johnson</u> (Address) <u>Port Deposit, Md.</u>					
15 Filed <u>9/7</u> 19 <u>30</u> <u>L. F. Sanders</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept-6</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug-2</u> , 19 <u>30</u> to <u>Sept 6-</u> , 19 <u>30</u> , that I last saw him alive on <u>Sept 6</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>1230</u> m. The CAUSE OF DEATH * was as follows: <u>Tuberculosis</u>					
(Duration) <u>2</u> yrs. <u>2</u> mos. <u>4</u> ds.					
Contributory Secondary					
(Signed) <u>B. J. Harrison</u> M. D. <u>96</u> 19 <u>30</u> Address <u>Port Deposit</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>30</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>30</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Where was disease contracted, if not at place of death? <u>Former or usual residence</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Opashun, Md.</u> DATE OF BURIAL <u>Sept 9, 1930</u>					
20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Temple</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

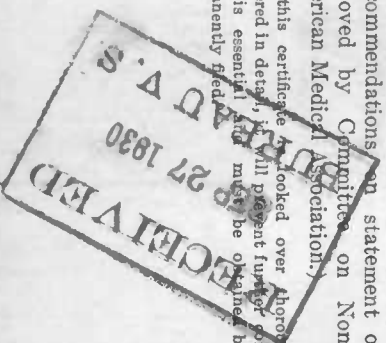
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL eclampsia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

06604

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH May 4<sup>th</sup> 1918 (Month) (Day) (Year)

7 AGE 12 yrs. 1 mos. 23 ds. or min. (If LESS than 1 day hrs.)

8 OCCUPATION (a) Trade, profession or particular kind of work Scholar (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Mrs. J. Devine

11 BIRTHPLACE OF FATHER Md (State or country)

12 MAIDEN NAME OF MOTHER Annette Vansant

13 BIRTHPLACE OF MOTHER Md (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Devine (Address) Elkton, Md. R. 1

15 Filed June 28 1930 J. Paul Hays Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 27<sup>th</sup> 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1921 to 1921, that I last saw her alive on 6/27, 1930

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH \* was as follows:

from information -  
Accidental Drowning.  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) J. Paul Hays M. D. (Address) 1921

\*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery DATE OF BURIAL June 29, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Fireman, (b) Automobile factory.* The material on may form part of the second statement, as *Turn "Laborer," "Foreman," "Manager," "Dealer,"* without more precise specification as *Day Laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Cancer*, *Sore throat, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU OF

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
 County Cecil

Village or City Ecdobee (No. 44)

2 FULL NAME Franklin Diggs

07830  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
 (Write the word)

6 DATE OF BIRTH January 31, 1866  
 (Month) (Day) (Year)

7 AGE 65 yrs. 5 mos. 6 ds. or min.?  
 If LESS than 1 day hrs.

8 OCCUPATION  
 (a) Trade, profession or particular kind of work Insurance Agent  
 (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Wm Diggs

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Warren

13 BIRTHPLACE OF MOTHER (State or Country) No Information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Franklin Diggs Jr.  
 (Address) 506 Baltimore Ave  
Johnson Md.

15 Filed July 7 1923 Franklin Diggs Jr.  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 7, 1923  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 23, 1920, to July 7, 1923, that I last saw him alive on July 7, 1923,

and that death occurred on the date stated above, at 1:30 a.m., The CAUSE OF DEATH \* was as follows:

Carcinoma of Liver & Pancreas.  
Three years.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) V. H. McHugh M. D.  
July 7, 1923 (Address) Ecdobee Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?  
 Former or usual residence North East Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Louder Park Cemetery Baltimore July 9, 1930  
 20 UNDERTAKER ADDRESS  
N. W. Pippin Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 7 1930  
BUREAU V S.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. E.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit

2 FULL NAME May Josephine Droney

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 10, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 1 mos. 17 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Tauquien Co. Va.

10 NAME OF FATHER J. W. Cassell

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Silver Cross Home  
(Address) Port Deposit, Md

15 File July 27 1930 L. Sanders  
Registrar

07891

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from July 26, 1930 to July 26, 1930  
that I last saw him alive on July 26, 1930

and that death occurred on the date stated above, at 7:10 m.  
The CAUSE OF DEATH \* was as follows: AM

Epilepsy  
Epileptic Insanity  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary

(Signed) B. J. Harrison M. D.  
7/27/30 (Address) Port Deposit, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Calverton Va DATE OF BURIAL July 29, 1930

20 UNDERTAKER H. Madison Mitchell ADDRESS Navy

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

13696

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

96

Village or City

Port Republic

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

James M. Doney

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

June 6

1929

(Month)

(Day)

(Year)

7 AGE

1 yrs. 5 mos. 5 ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Richard Doney

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Claire Thomas

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Richard Doney  
Port Republic, Md.

15 Filed

11/14/30

1930

J. F. Souders

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov-9-1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov-4-1930 to Nov-8-1930

that I last saw him alive on Nov-8-1930

and that death occurred on the date stated above, at 1:15 p.m.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. M. Penmon

M. D.

11/9

1930 (Address)

Port Republic, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, yrs. mos. ds.

In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cokesbury Baptist Church

Nov 11, 1930

20 UNDERTAKER

ADDRESS

Lee A. Patterson

Cokesbury

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

DEC 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital St. 92 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Still birth Townshon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Feb 8, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Cecil Co. Md

10 NAME OF FATHER Ellis W. Townshon

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Alice B. Sherman

13 BIRTHPLACE OF MOTHER (State or Country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S. Townshon  
(Address) Elk Mills Md.

15 Filed Feb 10 1930 Frank Boyer  
Registrar

01527

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on —, 192

and that death occurred on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH \* was as follows:

Still birth  
Premature delivery - 7 mos  
(Duration) yrs. mos. ds.

Contributory Fall on ice  
Secondary

(Signed) Herbert Baker M. D.  
1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cherry Hill Md DATE OF BURIAL Feb 10, 1930

20 UNDERTAKER A. J. Barnhart ADDRESS Elkton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery, (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hos St. Ward)

2 FULL NAME Mary E. Duckworth

06605 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept. 29<sup>th</sup>, 1891  
(Month) (Day) (Year)

7 AGE 38 yrs. 9 mos. — ds. or — min. ? If LESS than 1 day — hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER James M. Anderson

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Hoshall

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. Ethel B. Korner  
(Informant)

(Address) 515 W. Ave. Towson

15 Filed June 30, 1930 J. Frank Taylor  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 6/29, 1930,  
that I last saw her dead alive on 6/29, 1930.

and that death occurred on the date stated above, at 8.30 P. m.  
The CAUSE OF DEATH \* was as follows:

Revolver wound of the Abdomen  
(Duration) — yrs. — mos. — ds.

Contributory Probably accidental, cancer  
Secondary

(Signed) Howard W. Green Coroner  
6/29, 1930 (Address) Elkton md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Towson, md

DATE OF BURIAL June 30, 1930

20 UNDERTAKER W. M. Pippin

ADDRESS Elkton md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



1 PLACE OF DEATH			08501		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			8		Registration Dist. No. <u>96</u>	
Village or City <u>P. D. Davis</u> (No. _____)			St. _____		Ward) _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Still Birth Julio</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>SX</u>				
6 DATE OF BIRTH <u>July 31, 1930</u> (Month) (Day) (Year)						
7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. _____ ds. or _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Mo</u>						
PARENTS	10 NAME OF FATHER <u>Geo Julio</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Calif</u>					
	12 MAIDEN NAME OF MOTHER <u>Alic. Chevalain</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Canada</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alice Julio</u> (Address) <u>P. D. Davis</u>						
15 File <u>Aug 1</u> 192 <u>30</u> <u>L Sanders</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>July 31, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Still</u> 192 <u>30</u> to <u>July 31, 1930</u> that I last saw h. _____ alive on _____, 192 <u>30</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Still Birth</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. G. Jones</u> M. D. <u>July 31, 1930</u> (Address) <u>Rowlandville, Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>St. Paul Cemetery, Harford</u> DATE OF BURIAL <u>Aug 1, 1930</u>						
20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Carroll</u>						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Broncho pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Registration Dist. No. 8812

St.: ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16<sup>th</sup>, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
July 12<sup>th</sup> 1929. to June 16<sup>th</sup> 1930.  
that I last saw him alive on June 16<sup>th</sup> 1930.

and that death occurred on the date stated above, at 5:10 P.M.  
The CAUSE OF DEATH \* was as follows:

*Coronary Occlusion*

(Duration) ..... yrs ..... mos ..... ds.  
Contributory .....  
Secondary ..... Chronic myocarditis

(Duration) 1 yrs. 1 mos. 0 ds.  
(Signed) James E. McDonald M. D.  
192 (Address) Elkhart, Ind.

\*State the Disease Causing Death, or, in deaths from  
Accidental Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds.      In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or  
usual residence .....

19 PLACE OF BURIAL OR REMOVAL <i>Bethel (Ind) Cemetery</i>	DATE OF BURIAL <i>June 18, 30</i>
---	--------------------------------------

20 UNDERTAKER	ADDRESS
Harry G. Lawz	Champaign City Ill

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Tenant, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Form laborer, Loberer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic; cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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RECEIVED  
JUL 3 1930  
BUREAU



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1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME August Eisner

09120

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

6 DATE OF BIRTH January 6, 1857  
(Month) (Day) (Year)

7 AGE 73 yrs. 6 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Steel works

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Coroner's Investigation

(Address) Elkton, Md.

15 Filed 8/5 1930 L. F. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 8/5, 1930  
that I last saw him in dead on 8/5, 1930

and that death occurred on the date stated above, at 7.30 P. M.  
The CAUSE OF DEATH \* was as follows:

From information -  
Suicide by Drowning  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) 8/5 1930 (Address) \_\_\_\_ M. D.

\*State the Disease Causing Death, or the deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. Green, Coroner

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore, Md. DATE OF BURIAL Aug. 6, 1930

20 UNDERTAKER Lee G. Patterson ADDRESS Perryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

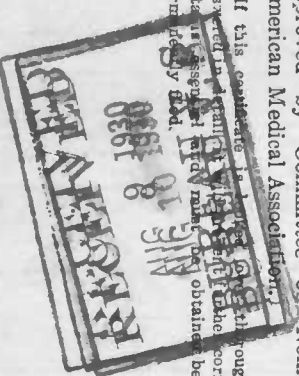
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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used for legal purposes, the death must be legally ascertained and the cause of death must be legally ascertained before the certificate is permitted to be used.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH					STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>					01528 (89)	
Village or City <u>Corryville</u> (No. _____)					St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Henry Elliott</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>				
6 DATE OF BIRTH <u>March 1, 1866</u> (Month) (Day) (Year)						
7 AGE <u>63</u> yrs. <u>11</u> mos. <u>12</u> ds. If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Hostler.</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>P. B. R. Co.</u>						
9 BIRTHPLACE (State or country) <u>Md.</u>						
10 NAME OF FATHER <u>George Elliott</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>						
12 MAIDEN NAME OF MOTHER <u>Matthias Peters.</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel Elliott</u> (Address) <u>Corryville, Md.</u>						
15 Filed <u>2/15</u> 19 <u>30</u> by <u>J. H. Sander</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Feb 13th</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 10</u> , 19 <u>30</u> to <u>Feb 13</u> , 19 <u>30</u> that I last saw him alive on <u>Feb 13</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Angina Pectoris</u> (Duration) ____ yrs. ____ mos. ____ ds. <u>Atheromata</u> (Duration) <u>3</u> yrs. ____ mos. ____ ds. Contributory Secondary (Signed) <u>J. F. Magraco</u> M. D. <u>Feb 14</u> 19 <u>30</u> (Address) <u>Corryville, Md.</u> *State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cem.</u>					DATE OF BURIAL <u>Feb 16, 1930</u>	
20 UNDERTAKER <u>Geo. A. Patterson</u>					ADDRESS <u>Corryville</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (c) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. hausion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 7 1940

BUREAU OF

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME Hilda Mae Fadeloy

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Sept 5, 1 2 (Month) (Day) (Year)

7 AGE 87 yrs. 4 mos. 5 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work at School (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Henry Fadeloy

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Ida M. Mahan

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Fadeloy

(Address) Perryville, Ind.

15 Filed 1/14 1930 J. H. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 13<sup>th</sup>, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 11<sup>th</sup>, 1930 to Jan. 13, 1930, that I last saw him alive on Jan. 12, 1930, and that death occurred on the date stated above, at 6a m.

The CAUSE OF DEATH \* was as follows:

Scarlet Fever

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Contributory Acute Myocarditis Secondary \_\_\_\_\_

(Signed) J. F. Magraw M. D. Jan 13, 1930 (Address) Perryville, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Angel Hill Hayford Co. DATE OF BURIAL Jan 14, 1930

20 UNDERTAKER Dr. A. Patterson ADDRESS Perryville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1930  
BUREAU

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1 PLACE OF DEATH County <u>Cecil</u>			04153 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>near Cecil</u> No. <u>99-2</u>			Registration Dist. No. <u>90</u>		
2 FULL NAME <u>Norma C. Farrow</u>			St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>—</u>	16 DATE OF DEATH <u>April 6, 1930</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>3 18 1930</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>April 2, 1930</u> to <u>April 6, 1930</u> , that I last saw her alive on <u>April 6, 1930</u> , and that death occurred on the date stated above, at <u>7:30 P.M.</u>		
7 AGE <u>19</u> yrs. <u>—</u> mos. <u>—</u> ds. or min.? If LESS than 1 day ____ hrs.			The CAUSE OF DEATH * was as follows: <u>Acute Catarrhal Bronchitis</u> <u>(Failure of respiration)</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)			(Duration) ____ yrs. ____ mos. <u>6</u> ds.		
9 BIRTHPLACE (State or country) <u>Cecil Co., Ind.</u>			Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.		
10 NAME OF FATHER <u>Clarence M. Farrow</u>			(Signed) <u>Dorsey W. Lewis</u> M. D. <u>April 7, 1930</u> (Address) <u>Middleton - Del.</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>			*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
12 MAIDEN NAME OF MOTHER <u>Elizabeth S. Short</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Delaware</u>			At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clarence M Farrow</u> (Address) <u>Essexville Md</u>			Where was disease contracted, if not at place of death? Former or usual residence _____		
15 Filed <u>4/7 1930</u> <u>J. C. Rowan</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Barretts Chapel</u> DATE OF BURIAL <u>April 8, 1930</u>		
			20 UNDERTAKER <u>John Haffage</u> ADDRESS <u>Cecil Co. Ind.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drapsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 3 1930  
BUREAU

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N B--Every item of information should be carefully supplied ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

05422

STATE OF MARYLAND  
CERTIFICATE OF DEATH 93

Registration Dist. No. 72

Village or City Belton, R.D. 5 (No. 129)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harriet Gertrude Ferguson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH January 2, 1865  
(Month) (Day) (Year)

7 AGE 65 yrs. 4 mos. 48 ds. or 48 min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jefferson Ferguson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jay

13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Hallett Jr  
(Address) Belton, Md. R.D. 5

15 Filed May 1, 1920 by J. Frank Frazier Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1 1918 to May 30 1920, that I last saw him alive on May 30 1920, and that death occurred on the date stated above, at 11:15 p.m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial nephritis

(Duration) 2 yrs. 1 mos. 1 ds.  
Contributory Chronic Nephritis  
Secondary Chronic Nephritis  
(Duration) 2 yrs. 1 mos. 1 ds.

(Signed) John H. Hallett M. D.  
1920 (Address) Belton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Friends Cemetery (Belton Md) DATE OF BURIAL June 3, 1920

20 UNDERTAKER C. J. Clemens ADDRESS Belton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1936  
BUREAU OF VITALS



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Cecil

Village or City Cecilton (No. \_\_\_\_\_)

2 FULL NAME John E. Ferguson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

9 24 1868  
(Month) (Day) (Year)

7 AGE

61 yrs. 6 mos. 19 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Cecil Co. Ind.

10 NAME OF FATHER

John E. Ferguson

11 BIRTHPLACE OF FATHER (State or country)

Cecil Co. Ind.

12 MAIDEN NAME OF MOTHER

Mary E. Jones

13 BIRTHPLACE OF MOTHER (State or country)

Cecil Co. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A

(Address) Cecilton Ind

15

Filed 4/15 1930

J. B. Rowan

Registrar

04154

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME, instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4 13 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1929 to Apr 13 1930

that I last saw him alive on Apr 13 1930

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

cardiac dilatation

(Duration) 1 yrs.  mos.  ds.

Contributory  
Secondary

(Duration)  yrs.  mos.  ds.

(Signed) Am Black M. D.

192 (Address) Cecilton

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death  yrs.  mos.  ds.

In the State  yrs.  mos.  ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cecilton Cemetery

April 16 1930

20 UNDERTAKER

ADDRESS

John D. Coffage

Cecilton, Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugsticker, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Coal mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 8 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME FERRY, Bradford C-Unknown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH  
January 26, 1895.  
(Month) (Day) (Year)7 AGE  
35 yrs. 5 mos. 30 ds. or min.  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Cabinet maker.  
(b) General nature of industry business, or establishment in which employed or (employer) ----9 BIRTHPLACE  
(State or country) Maryland.10 NAME OF FATHER  
Harry Perry11 BIRTHPLACE OF FATHER  
(State or country) Maryland.12 MAIDEN NAME OF MOTHER  
Maggie McKernan13 BIRTHPLACE OF MOTHER  
(State or Country) Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.15 Filed July 26 1930 Charles W. Thompson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
July 25, 1930.  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
July 24, 1930 to July 25, 1930.  
that I last saw him alive on July 25, 1930.  
and that death occurred on the date stated above, at 7:18 P.m.  
The CAUSE OF DEATH \* was as follows:  
Acute Nephritis following severe burns.Approximately 7 days.  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory Accidental burns by flaming  
Secondary gasoline  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 9 ds.(Signed) F. E. Leslie M. D.  
F. E. LESLIE Med. Officer in Charge.  
July 26, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 1 ds. In the State Unknown \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted, if not at place of death? Elkton, Md.Former or usual residence Elkton, Md.19 PLACE OF BURIAL OR REMOVAL  
H.W. Pippin, Elkton, Md.DATE OF BURIAL  
July 27, 1930.20 UNDERTAKER  
H. W. PippinADDRESS  
Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE

FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

14223

72

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME FIELD Everett M. C-None

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

8 DATE OF BIRTH

May 14, 1867  
(Month) (Day) (Year)

7 AGE

63 yrs. 6 mos. 16 ds. or min.?

If LESS than  
1 day... hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Lumber Inspector

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.

15 Filed 12/1 1930 by Charles W. Morrison  
ap Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 30, 1930.

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
June 16 1927 to November 30, 1930.

that I last saw him alive on November 30, 1930.and that death occurred on the date stated above, at 2:40 P.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage.(Duration) yrs. mos. ds. 1-14hrs.Contributory 1. Arteriosclerosis, cerebral.2. Tuberc. Dorsalis. 3. Nephritis, interstitial, chronic.(Duration) yrs. mos. ds. #1. Unknown. 2. 5 yrs.(Signed) F. E. Leslie, M.D. Officer in Charge. M. D.Dec. 1 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 11 mos. 3 ds. In the State 4 yrs. 11 mos. 3 ds.

Where was disease contracted, if not at place of death? UnknownFormer or usual residence 27 Corling St., Petersburg, Va.

19 PLACE OF BURIAL OR REMOVAL

Petersburg, Va.

DATE OF BURIAL

Dec. 3, 1930.

20 UNDERTAKER

B. Madison Mitchell, Havre de Grace, Md.  
R. Madison Mitchell

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

RECEIVED

JAN 5 1931

BUREAU

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovar wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			0327 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Perryville</u> (No. ....)			Registration Dist. No. <u>96</u>		
2 FULL NAME <u>William Jacob Finley</u>			St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)	16 DATE OF DEATH <u>January 27</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Feb. 2</u> , 18 <u>67</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 25</u> , 19 <u>30</u> , to <u>Jan 27</u> , 19 <u>30</u> , that I last saw him alive on <u>Jan. 26</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH * was as follows:		
7 AGE <u>62</u> yrs. <u>11</u> mos. <u>25</u> ds. or min.?			If LESS than 1 day hrs. min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter</u> (b) General nature of industry, business, or establishment in which employed or (employer) .....			Atheromata (Duration) <u>9</u> yrs. .... mos. .... ds.		
9 BIRTHPLACE (State or country) <u>Penna.</u>			Contributory Secondary <u>Apoplexy</u> (Duration) .... yrs. .... mos. <u>2</u> ds.		
PARENTS	10 NAME OF FATHER <u>Samuel Finley</u>		(Signed) <u>J. F. Magraw</u> M. D.		
	11 BIRTHPLACE OF FATHER <u>Penna.</u>		<u>Jan 27</u> , 19 <u>30</u> (Address) <u>Perryville, Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Sarah Hospro</u>		*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	13 BIRTHPLACE OF MOTHER <u>Penna.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Finley</u> (Address) <u>Perryville Md.</u> Where was disease contracted, if not at place of death? .....					
Former or usual residence .....					
15 FILED <u>Jan 27 1930</u> <u>L. F. Sanders</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>River View Bur.</u> DATE OF BURIAL <u>Jan 29</u> , 19 <u>30</u>		
			20 UNDERTAKER <u>Wilmington Del.</u> ADDRESS <u>Lee A. Patterson Perryville Md.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County Cecil

14862

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME FLEIGHT, Frederick G. XC-416 196

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH

Unknown 1885  
(Month) (Day) (Year)

7 AGE

45 yrs. - mos. - ds. or min.?If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Coal miner

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Pennsylvania10 NAME OF  
FATHERLouis Fleight11 BIRTHPLACE  
OF FATHER  
(State or country)Germany12 MAIDEN NAME  
OF MOTHERUnknown13 BIRTHPLACE  
OF MOTHER  
(State or Country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Perry Point, Md.

15

Filed 12/31/30 192 Charles W. Morrison  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 31, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

November 4 1927 to Dec. 31, 1930that I last saw him alive on Dec. 31, 1930and that death occurred on the date stated above, at 4:50 A. m.

The CAUSE OF DEATH \* was as follows:

Tuberculosis, Pulmonary, chronic, active,  
far advanced (Type P&R)(Duration) 2 yrs. 11 mos. 11 ds.Contributory  
SecondaryDementia Praecox, HebephrenicType, pronounced (Duration) 4 yrs. 4 mos. 4 ds.(Signed) W.A. Ellison M. D.W.A. ELLISON, Acting Med. Officer in Ch.Dec. 31 1930. (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 2 mos. 25 ds. In the State Unknown ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 1822 Larkinsway, Pittsburgh, Pa.19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Undertaker J.P. Colligan Bros. S.S.  
Pittsburgh, Pa. 800 Carson St. Jan. 3, 193120 UNDERTAKER ADDRESS  
R. Madison Mitchell, Havre de Grace, Md.  
R. Madison Mitchell

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1917  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. \_\_\_\_\_)

2 FULL NAME Charles T. Foard

05423 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 8 1866  
(Month) (Day) (Year)

7 AGE 63 yrs. 11 mos. 30 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer (ret)  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE Mc Donough, Delaware  
(State or country)

10 NAME OF FATHER Eli Josiah Foord

11 BIRTHPLACE OF FATHER Delaware  
(State or country)

12 MOTHER'S NAME OF MOTHER Mary E. Bilany

13 BIRTHPLACE OF MOTHER Wilmington, Del  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Foard  
(Address) \_\_\_\_\_

15 Filed May 8 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 16 1930 to May 7 1930, that I last saw him alive on May 7, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:  
Chronic valvular heart disease

Contributory Secondary \_\_\_\_\_

(Signed) J. P. Brien M. D.  
192\_\_\_\_ (Address) Chesapeake City, Md.

\*State the 1) Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bethel Cemetery May 10, 1930

20 UNDERTAKER ADDRESS

H. W. Pippin Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930  
BUREAU V. 8.

WRITE

PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. PLACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME James Franklin Foreaker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Mar 17, 1876  
(Month) (Day) (Year)

7 AGE 53 yrs. 10 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Peet & Lile Co

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Foreaker

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Lenon

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Dick

(Address) Elkton, Md

15 Filed Feb 4 1930 James Foreaker Registrar

01529

(66)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 1 1930 to Feb 2, 1930, that I last saw him alive on Feb 1, 1930,

and that death occurred on the date stated above, at 39 m.

The CAUSE OF DEATH \* was as follows: Acute alcoholism

(Duration) Not known ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) M. T. Morrison M. D.  
Feb 4, 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. Coroner

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Elkton Catholic Cemetery DATE OF BURIAL Feb 5, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU V 5

MARGIN RESERVED FOR BINDING

V. S. No. 1

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

06607

(66)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City U.S. Veterans' Hospital, Perry Point, Md. St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME FOSTER, Willard H. C-1 375 855

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH November 19, 1891  
(Month) (Day) (Year)

7 AGE 38 yrs. 6 mos. 21 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Security Salesman  
(b) General nature of industry, business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Des Moines, Iowa.

10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records  
(Address) Perry Point, Md.

15 Filed June 10, 1930 Charles W. Morrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 6, 1930 to June 10, 1930, that I last saw him alive on June 10, 1930, and that death occurred on the date stated above, at 10:08 P.m. The CAUSE OF DEATH \* was as follows: Chronic Alcoholism.

(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary ---

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) T.F. NEIL Acting Med. Officer in Ch. June 11, 1930 (Address) Perry Point, Md. M. D.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 4 ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 801 N. Monroe St., Balto., Md.

19 PLACE OF BURIAL OR REMOVAL Undertaker: Durin Funeral Home, June 14, 1930  
Des Moines, Iowa. DATE OF BURIAL June 14, 1930

20 UNDERTAKER Pennington & Son, Havre de Grace, Md. ADDRESS       

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Painter, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia*, ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1934  
BUREAU

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. MIS-CELLANEOUS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City North East (No. ....)

2 FULL NAME William B Foster

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 94

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower  
(Write the word)

6 DATE OF BIRTH Dec 21 1869  
(Month) (Day) (Year)

7 AGE 60 yrs. 9 mos. 11 ds. or 60 yrs. 9 mos. 11 ds. If LESS than 1 day, .... hrs. or .... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Foreman Iron foundry  
(b) General nature of industry, business, or establishment in which employed or (employer) retired 8 years

9 BIRTHPLACE  
(State or country) md

10 NAME OF FATHER William F. Foster

11 BIRTHPLACE OF FATHER  
(State or country) md

12 MAIDEN NAME OF MOTHER Mary E Talley

13 BIRTHPLACE OF MOTHER  
(State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Doris Foster

(Address) Elleston md

15 Filed Oct 2 1930 Geo W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 2nd 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 27 1930 to Oct 27 1930, 192...  
that I last saw him alive on Oct 27 1930, 192...  
and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Apoplexy

Contributory Chronic Intermittent nephritis  
Secondary (Duration) 3 hrs mos. ds.

(Signed) H. C. Owens M. D.  
Oct 4 1930 (Address) Wm. Talley

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence, ....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M.E. Cemetery Oct 5, 1930

20 UNDERTAKER ADDRESS

Joseph R. Evans North East

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

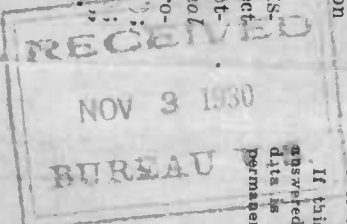
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Wagon laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-potential meningitis*; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *labor pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rancher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data are essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		14863		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>		18-c		Registration Dist. No. <u>97</u>	
Village or City <u>Chester</u> (No. <u>1111</u> )		St. <u>St. Joseph</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Angeline A. Ranzese</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Mar 23</u> , 19 <u>10</u> (Month) (Day) (Year)					
7 AGE <u>20</u> yrs. <u>8</u> mos. <u>9</u> ds. or min. If LESS than 1 day hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Italy</u>					
PARENTS	10 NAME OF FATHER <u>Antonio Ranzese</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u>				
	12 MAIDEN NAME OF MOTHER <u>Giovanna Ranzese</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Italy</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>M. Lepore</u>					
(Address) <u>217 1st St. New York 12</u>					
15 Filed <u>Dec 2</u> 19 <u>30</u> <u>J. Frank Bay</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Dec 1</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>6:16 P.m.</u>					
The CAUSE OF DEATH * was as follows: <u>Sepsis meningitis</u> <u>Pulvis meningitis</u>					
(Duration) yrs. mos. ds.					
Contributory Secondary <u>Myocardial infarction</u>					
(Duration) yrs. mos. ds.					
(Signed) <u>H. A. Campbell</u> M. D.					
Dec 2 1930 (Address) <u>New York</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted if not at place of death? <u>New York</u>					
Former or usual residence <u>New York</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Asbury Park Cemetery</u>					
DATE OF BURIAL <u>Dec 3</u> , 19 <u>30</u>					
20 UNDERTAKER <u>Joseph P. Grant</u>					
ADDRESS <u>New York</u>					

If more blanks are needed, address State Registrar, 16 W. Santiago St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
DEC 5 1934



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Cecil</u> Village or City <u>Near Charlestown</u> (No. <u>128-C</u> )		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>94</u>	
2 FULL NAME <u>Antonio Franzese</u>		St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Unknown</u> 1884 (Month) (Day) (Year)			
7 AGE <u>46</u> yrs. ____ mos. ____ ds. or ____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Shoemaker</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Italy</u>			
10 NAME OF FATHER <u>Frank Franzese</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u>			
12 MAIDEN NAME OF MOTHER <u>Beatrice Pascala</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Italy</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>M. Lepore</u> (Address) <u>217 Matt St New York City</u>			
15 Filed <u>11-30-36</u> 192 <u>Geo W. Green</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov 27</u> 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> that I last saw him <u>dead</u> on <u>11/27</u> 19 <u>30</u> and that death occurred on the date stated above, at <u>5.30 P.m.</u> The CAUSE OF DEATH * was as follows: <u>Fractured Skull</u>			
Contributory Secondary (Duration) yrs. ____ mos. ____ ds. <u>Auto accident</u>			
(Signed) <u>Howard W. Green</u> M.D. <u>11/27/30</u> (Address) <u>Elkton Md.</u>			
*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.			
Where was disease contracted, if not at place of death? _____			
Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Asbury Mc Cem</u>		DATE OF BURIAL <u>Dec. 1, 1930</u>	
20 UNDERTAKER <u>Joseph R. Grant</u>		ADDRESS <u>North East, Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

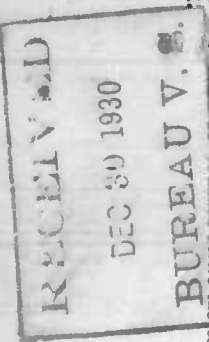
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Méasles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Cecil</u>		14225		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Charlestown</u> (No. <u>188-c</u> )		Registration Dist. No. <u>74</u>		St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Franzese</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Unknown</u> , 19 <u>11</u> (Month) (Day) (Year)					
7 AGE <u>19</u> yrs. _____ mos. _____ ds. or _____ min.? If LESS than 1 day _____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Italy</u>					
PARENTS					
10 NAME OF FATHER <u>Antonio Franzese</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u>					
12 MAIDEN NAME OF MOTHER <u>Giovannina Lepore</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Italy</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>M. Lepore</u> (Address) <u>217 Mott St., New York City</u>					
15 Filed <u>11-30-30</u> 19 <u>2</u> <u>E. W. Green</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 27<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from 19 <u>2</u> to _____, 19 <u>2</u> , that I last saw her <u>alive</u> on <u>11/27</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>5:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Fractured Skull</u>					
Contributory Secondary <u>Auto accident</u> (Signed) <u>Howard W. Green</u> (Duration) _____ yrs. _____ mos. _____ ds. (Address) <u>Expton Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Asbury ME. Cem.</u>				DATE OF BURIAL <u>Dec. 1</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Joseph R. Grant</u>				ADDRESS <u>North East, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

0361 G3 329

DEATH

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Cecil

Village or City Elkton Union Hospital (No. 74-a)

FULL NAME George H. Freet

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward) (if death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 26, 1896 (Month) (Day) (Year)

7 AGE 34 yrs. 4 mos. 10 ds. or min. IF LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Rigger. (b) General nature of industry, business, or establishment in which employed or (employer) U.S. Government D & C Canal

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Freet

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER May Hines

13 BIRTHPLACE OF MOTHER (State or country) Illand

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Freet (Address) Chesapeake City Md

15 Filed May 7, 1920 J. Frank Jase Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 6, 1930 to May 6, 1930 that I last saw him alive on May 6, 1930 and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows: Coronary Artery Disease

Contributory Secondary

(Signed) Jacob J. ... M. D. (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL May 8, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer on Planter, Physician, Composer, Archivist, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 8 1907

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			14236	Registration Dist. No. <u>95</u>
Village or City <u>near Oakwood</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Eugene Fulton</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Dec 10, 1873</u> (Month) (Day) (Year)				
7 AGE <u>56</u> yrs. <u>11</u> mos. <u>15</u> ds. If LESS than 1 day ____ hrs. or ____ min.?				
OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Ind.</u>				
10 NAME OF FATHER <u>Alexander Fulton</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>				
12 MAIDEN NAME OF MOTHER <u>May Emma Evans</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pa.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Andrew C. Fulton</u> (Address) <u>Crownings Ind.</u>				
15 Filed <u>12-1-30</u> Registrar <u>L. M. M. M. M. M.</u>				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Nov 25</u> , 19 <u>2</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>11/29</u> , 19 <u>2</u> that I last saw him <u>alive</u> on <u>11/29</u> , 19 <u>2</u> and that death occurred on the date stated above, at <u>130P</u> m. The CAUSE OF DEATH * was as follows: <u>Drowning</u> (Duration) ____ yrs. ____ mos. ____ ds.				
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>Howard W. Green</u> M.D. <u>11/29/30</u> (Address) <u>Elkton Md</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Pleasant Grove Pa.</u>			DATE OF BURIAL <u>Dec 2, 1930</u>	
20 UNDERTAKER <u>J. C. Syson</u>			ADDRESS <u>Highland Ind</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 12-1-30

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU OF

JAN 3 1931

V. S. No. 1

1 PLACE OF DEATH  
County Cecil

Village or City Earlville No. 2

2 FULL NAME Margaret Galt

05425 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR, OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed
-----------------	---------------------------	--

6 DATE OF BIRTH April 15, 1864  
(Month) (Day) (Year)

7 AGE 65 yrs. 0 mos. 20 ds. or min. If LESS than 1 day..... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Name  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Delaware

10 NAME OF FATHER Garrison Bogles

NTS 11 BIRTHPLACE  
OF FATHER  
(State or country) *Belarus*

12 MAIDEN NAME OF MOTHER *don't know*

13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harvey Biddle  
(Address) Essexville Ind. Ind.

15 Filed 5/7 19230 J. O. Cravan  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1930  
(Month) (Day) (Year)

7. I HEREBY CERTIFY, That I attended the deceased from  
May 4 1930 to May 4 1930  
that I last saw her alive on May 4 1930  
and that death occurred on the date stated above, at 9:00 P.m.  
The CAUSE OF DEATH \* was as follows:

Central Kennel Club -

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary      Arterial Sclerosis

(Duration) 1 yrs. 0 mos. 0 ds.  
(Signed) Caroline Goodson M. D.  
Mar 7 1930 (Address) Chillicothe, Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
11 1 21 11	11 1 21 11

Union Church Cemetery, May 8, 1930  
20 UNDERTAKER ADDRESS  
W. H. Daniels Townsend

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *chopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

WITHIN CORPORATE LIMITS OF

04155 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ella May Garrett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

July

7

(Month)

(Day)

1861

(Year)

7 AGE

68

yrs.

6

mos.

27

ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Michael Hartnett

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Julia Murphy

13 BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Garrett

(Address)

Elkton Md

15 Filed

April 7 1930

J. Frank Mager  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 4

1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 29 1930 to April 4 1930

that I last saw her alive on April 3 1930

and that death occurred on the date stated above, at 12:50 A. M.

The CAUSE OF DEATH \* was as follows:

Cerebral Apoplexy

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

(Signed)

Herbert B. Bates M. D.  
4/5 1930 (Address) Elkton Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Catholic Cemetery

DATE OF BURIAL

Apr 7 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugistician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E-haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1930

BUREAU OF

## PARENTS

15 Filed March 25 1963 *Dr. Frank Meyer*

(Address) Elkhon Md.

(Informant) Ben Zarek

(State or Country) *Massachusetts*

12 MAIDEN NAME  
OF MOTHER *Elisabeth Walland*

NTS 11 BIRTHPLACE  
OF FATHER  
(State or country) *Maryland*

10 NAME OF FATHER *Paul C.*

9 BIRTHPLACE  
(State or country)

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

8 OCCUPATION  
(a) Trade, profession or particular kind of work *Homemaker*

7 AGE 66 yrs. 3 mos. 2 ds. If LESS than  
1 day.....hrs.  
or.....min.?

6 DATE OF BIRTH Dec 24, 1864  
(Month) (Day) (Year)

3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
-----------------	----------------------------	--

### PERSONAL AND STATISTICAL PARTICULARS

2 FULL NAME Laurea Farrell

Village or City College (No. 1000)

County Vol

1 PLACE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Mar. 25<sup>th</sup> 1920. to March 25<sup>th</sup> 1920  
that I last saw him alive on March 25<sup>th</sup> 1920  
and that death occurred on the date stated above, at 1.40 p.m.  
The CAUSE OF DEATH \* was as follows:

### Contributory Secondary

(Duration) ..... yrs. .... mos. .... da.  
(Signed) V. H. McKnight ..... M. D.  
3-26 1970 (Address) College Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

**18 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.      In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elkton Colored Cemetery	March 29, 1930.

20 UNDERTAKER	ADDRESS
H. W. Phipps	Elkton Md.

if more books are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St.:.....Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

WITHIN CORPORATE LIMITS OF

02810

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 11 1930

RUB

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Union Hospital, Elkins, Md. (No. 113)

2 FULL NAME Myrtle V. Gatewood

05426 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Oct 31 1929  
(Month) (Day) (Year)

7 AGE 6 yrs. 9 mos. 9 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co, Ind.

10 NAME OF FATHER Raymond Gatewood

11 BIRTHPLACE OF FATHER (State or country) Cecil Co, Ind.

12 M maiden NAME OF MOTHER Ada Edwards

13 BIRTHPLACE OF MOTHER (State or Country) Cecil Co, Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ada Gatewood  
(Address) Earleville md

15 Filed May 10 1930 Frank France Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 7 1930 to May 9 1930  
that I last saw her alive on May 8 1930

and that death occurred on the date stated above, at 1:30 A.M.  
The CAUSE OF DEATH \* was as follows:

Acute Gastritis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Improper food  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Caroline Goodson M. D.  
192 \_\_\_\_\_ (Address) \_\_\_\_\_

\*State the cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cecil Co, Ind. May 11 1930

20 UNDERTAKER ADDRESS John H. Caffage Cecil Co, Ind.



*For substitution to change word "see third certificate 10/31/37. A.S. 6/15/38."*

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pastrycook, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphæxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Heavily wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated. ACTING PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

01530

STATE OF MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Cecil

(59)

Registration Dist. No. 94

Village or City North East P.D. #2 (No.     )

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Walter A George

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 6, 1866  
(Month) (Day) (Year)

7 AGE 63 yrs. 5 mos. 28 ds. or      min. If LESS than 1 day      hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Joseph George

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillie Rothwell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret George  
(Address) North East P.D. #2 Md

15 Filed 2-5-30 1920 Geo. W. Owens  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feby. 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feby 3 1930 to Feby 3 1930, that I last saw him dead on Feby 3 1930 and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH \* was as follows:  
Angina Pectoris  
(Duration) 1 yrs.      mos.      ds.

Contributory Secondary       
(Duration)      yrs.      mos.      ds.  
(Signed) C. J. Stevens M. D.  
Feby 5 1930 (Address) North East, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.  
Where was disease contracted, if not at place of death?     

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL North East M. E. Cemetery DATE OF BURIAL Feb 6, 1930

20 UNDERTAKER Joseph P. Grant ADDRESS North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Scar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (c. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little care is essential and must be obtained before the certificate is permanently filed.

RECORDED  
INDEXED  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Cecil

Village or City

Near Elktown

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Floyd Gibson

 14864 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 92

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

no information, 1

7 AGE

about 32

If LESS than

1 day \_\_\_\_\_ hrs.

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Seaman

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 12 1920

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 2, 1920

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17 I HEREBY CERTIFY, That I attended the deceased from

1920, to \_\_\_\_\_, 1920

that I last saw him alive on \_\_\_\_\_, 1920

and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH \* was as follows:

Fractured Skull

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Howard W. Green, M.D.  
12/2/1920 (Address) Elktown, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

County burial Cemetery

DATE OF BURIAL

Dec 12, 1920

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elktown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 7 1931  
BUREAU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. If the CAUSE OF DEATH is in plain terms so that it may be properly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

01531

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

94

Village or City

North East

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Gilbert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

widowed

6 DATE OF BIRTH

July

10

(Month)

(Day)

1872

(Year)

7 AGE

57 yrs.

7 mos.

7 ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

New York

10 NAME OF FATHER

Charles Benjamin

11 BIRTHPLACE OF FATHER

(State or country)

New York

12 MAIDEN NAME OF MOTHER

Fuller

13 BIRTHPLACE OF MOTHER

(State or country)

New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marion Poake

(Address)

P.O. Croton on Hudson

15

Filed 2-18-30 192

Geo. W. Quinn

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 17

(Month)

(Day)

1930

17 I HEREBY CERTIFY, That I attended the deceased from

Apr 20

1929

to

July 17

1930

that I last saw her alive on

July 16

1930

and that death occurred on the date stated above, at

8 A

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial  
Nephritis

(Duration) yrs 10 mos ds.

Contributory  
Secondary

(Signed)

C. J. Shaw M. D.

Feb 18 1930 (Address) North East Md

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peebles New York Feb 19 1930

20 UNDERTAKER

ADDRESS

Joseph R. Shaw North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return  *laborer*, "*Foreman*," "*Manager*," "*Dealer*," et., without more precise specification as *Bag laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*cardiopycnotic fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 21 1920  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

4/28

192

L. F. Sanders

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

April 22<sup>nd</sup> 1930 to April 25, 1930,

that I last saw him alive on April 25, 1930,

and that death occurred on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

April 26, 1930

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PLACE OF DEATH

County

Village or City

FULL NAME

07893

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

July 11, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit saved 7-11-1930



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Acie

Village or City M Rising Sun (No. 90)

2 FULL NAME Rebecca Golden

05427 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown about 1883  
(Month) (Day) (Year)

7 AGE 47 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min. if LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) Housewife

9 BIRTHPLACE (state or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rebecca Golden  
(Address) Childs Rd

15 Filed May 18 1930 Registrar John W. Montgomery

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2-14 1930 to 5-13 1930

that I last saw him alive on 5-11 1930

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Rebecca Golden M. D.  
5/13/30 (Address) Rising Sun Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Trinity Cem May 17 1930

20 UNDERTAKER ADDRESS

Clyde E. Mason Chifford Pa.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal meningitis*); *Epidemic cerebrospinal meningitis*; *Diphtheria* (avoid use of "Cholera"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 8 1930  
BUREAU

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated. ACTUALLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

01532

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

(129)

Village or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary E. Goodnow

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Apr 30 1859  
(Month) (Day) (Year)

7 AGE 70 yrs. 9 mos. 26 ds. or min.?  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Samuel Logan  
11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Bennet

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Goodnow  
(Address) North East md

15 Filed 2-18-30 192 Geo W. Quess  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 15 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1 1930 to Feb 13 1930,  
that I last saw him live on Feb 13 1930,  
and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 6 mos. 6 ds.  
Contributory Arteriosclerosis & Coronary  
Secondary

Signed Dr. C. C. Curfewell M. D.  
Feb 15 1930 (Address) North East

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East M. E. DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Joseph R. Hunt ADDRESS North East

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITING ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH

AGE

If LESS than  
1 day, hrs.  
OR min. ?

OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry  
business, or establishment to  
which employed (or employer)

BIRTHPLACE  
(State or country)

## PARENTS

10 NAME OF  
FATHER

11 BIRTHPLACE  
OF FATHER  
(State or country)

12 MAIDEN NAME  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER  
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

1930

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Pericardial Anemia

Family History of this 3 years

(Duration) 3 yrs. mos. ds.

Contributory Cordial Anemia

Secondary

(Signed) Ernest Fordland

Aug 7, 1930 Address Liberty Grove Md

\*State the DISEASE CAUSING DEATH, or, in months from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted?  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Pneumopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Trismus," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspond-ence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 4 1930

BUREAU V

WRITE

FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Chesapeake City No. 161-a

<sup>2</sup> FULL NAME Infant Gorman

05428 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH May 20, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day 4 hrs. \_\_\_\_\_  
0 yrs. 0 mos. 0 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Md

10 NAME OF FATHER Geo. Ernest Gorman

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Pearl May Howell

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. E. Gorman  
(Address) Ches. City Md

15 Filed 5/22 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 20, 1930 to May 21, 1930, that I last saw him alive on May 21, 1930, and that death occurred on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH \* was as follows:

Congenital debility -  
Premature delivery

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Bales M. D.  
5/24 1930 (Address) Reisterstown Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel (Md) Cemetery DATE OF BURIAL May 21, 1930

20 UNDERTAKER Harry G. Laws ADDRESS Chesapeake City Md

# REVISED UNITED STATES STANDARD - CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Preliminary statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal meningitis*; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1900  
BUREAU V. B.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Fannie L. Graves

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 25, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 5 mos. 21 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Domestic Servant  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Dickinson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertie White

(Address) Elkton, Md

15 Filed Aug 19 1920 Frank Taylor Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 16, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 11, 1920 to Aug 16, 1920

that I last saw her alive on Aug 13, 1920

and that death occurred on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 17 ds.

Contributory unknown  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. H. McKnight M. D.

Aug 19 1920 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton, Colored Cemetery DATE OF BURIAL Aug 19, 1920

20 UNDERTAKER H. W. Pippin ADDRESS Elkton, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Becil County

0328

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95Village or City Rising Sun (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Joseph P. Gray

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED, married  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Jun 24, 1841  
(Month) (Day) (Year)

7 AGE

88 yrs. 11 mos. 10 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Virginia

10 NAME OF FATHER

John Gray

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Reynolds

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Elizabeth Barrett

(Address)

Rising Sun, Md.

15

Filed

1030

John M. Huntington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 4, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 21, 1929 to death, 1929.that I last saw him alive on Dec 31, 1929

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Paralytic Stroke(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. B. Sledge

M. D.

1/41929 (Address)Rising Sun

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brook View, Ind.Jan 5, 1930

20 UNDERTAKER

ADDRESS

L. C. Tyson.Rising Sun, Md.Permit issued 1/4-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

FEB 4 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Cecil*  
Near *Port Deposit*  
Village or City

07894

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *96*

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*William Gray*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
(Write in words)

6 DATE OF BIRTH *Nov. 2, 1900*  
(Month) (Day) (Year)

7 AGE *29* yrs. *8* mos. *4* ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work *Laborer*  
(b) General nature of industry business, or establishment in which employed or employed by *Stone Quarry*

9 BIRTHPLACE (State or country) *N. Carolina*

10 NAME OF FATHER *W. J. Gray*

11 BIRTHPLACE OF FATHER (State or country) *Carolina*

12 MAIDEN NAME OF MOTHER *Laura Reed*

13 BIRTHPLACE OF MOTHER (State or country) *N. Carolina*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Address

15 Filed *July 9, 1920*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 6, 1920*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *1920* to *1920*

that I last saw him *dead* on *7/8, 1920*

and that death occurred on the date stated above, at *8:30 P. M.*

The CAUSE OF DEATH \* was as follows:

*From information*

*Accidental Drowning*

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

1920 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal  
*Heart Failure (Coroner)*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Cokesbury Ave.* DATE OF BURIAL *July 9, 1920*

20 UNDERTAKER *Lee A. Patterson* ADDRESS *Brydgate*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE

CORD

CORD

CORD

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Lula B Green

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH no information, 1870  
(Month) (Day) (Year)

7 AGE 60 yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Servant  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) North Carolina

10 NAME OF FATHER no information

11 BIRTHPLACE OF FATHER (State or country) no information

12 MAIDEN NAME OF MOTHER no information

13 BIRTHPLACE OF MOTHER (State or Country) no information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Mitchell

(Address) Elkton Md

15 Filed Apr 16 19230 James Trayer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 30 to Sept 14, 1930, that I last saw him alive on Sept 12, 1930, and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis  
myocarditis (Duration) \_\_\_\_ yrs. 6 mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Herbert B. Baker M. D.  
9/15 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Colored Cemetery DATE OF BURIAL Sept 16, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU V. S.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County

*Cecil*  
 Near *Elkton* (No. \_\_\_\_\_)

2 FULL NAME

*Frank L. Gregson*

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male white*

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (State the event)

*Married*

6 DATE OF BIRTH

*Aug. 12<sup>th</sup>, 1903*

7 AGE

*26* yrs. *11* mos. *15* ds. or *15* min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

*Brook Brakeman*

9 BIRTHPLACE (State or country)

*md*

10 NAME OF FATHER

*Wm. J. Gregson*

11 BIRTHPLACE OF FATHER

(State or country)

*md*

12 MOTHER'S NAME OF MOTHER

*Mattie Hutton*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Pa.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John Gregson*

(Address)

*Elk Mills, Md*

15

*Filed July 27 1923*

*Frank Trayer*  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 27<sup>th</sup>, 1923*

17

I HEREBY CERTIFY, That I attended the deceased from

*1923* to *1923*  
 that I last saw him *alive* on *7/27/23*

and that death occurred on the date stated above, at *11:45 A.M.*  
 The CAUSE OF DEATH \* was as follows:

*from information -*  
*Accidental Drowning*

Contributory Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_ 1923 (Address)

\*State the disease causing death, or, in deaths from Violent Causes, State the Means of Injury and (if) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Wilmington Del* *July 28, 1923*

20 UNDERTAKER ADDRESS

*Albert J. McCreary* *Wilmington Del*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

215 Kuetayak ex

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Registrar

13697

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in  
a hospital or institution,  
give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

11/21/30 (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningies, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit (No. \_\_\_\_\_)

2 FULL NAME Oliver Parker Hagerty

01533

7401

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME in stead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb. 10 1870  
(Month) (Day) (Year)

7 AGE 60 yrs. 0 mos. 0 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER James S. Hagerty

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Smiley

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. O. P. Hagerty

(Address) Port Deposit Md.

15 Filed Feb 11th 1921 L. S. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb - 10, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb - 5 1920 to Feb - 9 1920  
that I last saw him alive on Feb - 9, 1920

and that death occurred on the date stated above, at 5 A. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage  
Paralysis of left side

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) C. O. Benson M. D.  
710 1920 (Address) Port Deposit Md.

\*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holywell Cem. DATE OF BURIAL Feb 12, 1920

20 UNDERTAKER Lea Patterson ADDRESS Port Deposit Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 7 1938  
BUREAU

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1 PLACE OF DEATH  
County Cecil

Village or City Earleville (No. 74-a)

2 FULL NAME Margaret E. Haggerty

12333 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH 7 4 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 3 mos. 12 ds. or min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Md.

PARENTS  
10 NAME OF FATHER James Clark  
11 BIRTHPLACE OF FATHER (State or country) Ireland  
12 MAIDEN NAME OF MOTHER Maria Husfeldt  
13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John A. Craig  
(Address) Earleville Md.

15 Filed 10-18 1930 Chawau  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 16 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 9th 1930 to Oct 15th 1930, that I last saw her alive on Oct 15 1930, and that death occurred on the date stated above, at 3 a. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory (Duration) yrs. mos. 7 ds.  
Secondary Arterio Sclerosis

(Signed) Am. Black M. D.  
Oct 17 1930 (Address) Cecil Co. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Pauls Cemetery DATE OF BURIAL Oct 19th 1930

20 UNDERTAKER John H. Caffrey ADDRESS Chawau, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

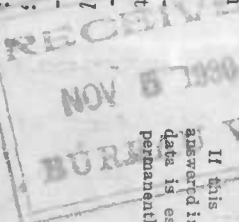
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
1 PLACE OF DEATH County <u>Cecil</u>	2 FULL NAME <u>Maria Haines</u>		16 DATE OF DEATH <u>Aug. 6, 1930</u> (Month) (Day) (Year)	
Village or City <u>Conowingo</u> (No. _____) St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug 1, 1930</u> to <u>Aug 6, 1930</u> that I last saw her alive on <u>Aug. 6, 1930</u>	
6 DATE OF BIRTH <u>Sept 3, 1869</u> (Month) (Day) (Year)	7 AGE <u>60</u> yrs. <u>11</u> mos. <u>3</u> ds. or min.?		and that death occurred on the date stated above, at <u>1308</u> m. The CAUSE OF DEATH * was as follows: <u>Arteriosclerosis</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		9 BIRTHPLACE (State or country)		
<u>Housework</u>		<u>Ind.</u>		
10 NAME OF FATHER <u>George Barnes</u>		11 BIRTHPLACE OF FATHER <u>Ind.</u>		
12 MAIDEN NAME OF MOTHER <u>Catziak Harris</u>		13 BIRTHPLACE OF MOTHER <u>Ind.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Maria Haines</u> (Address) <u>Conowingo Ind.</u>				
15 FILED <u>Aug 8, 1930</u> <u>Emm Washington</u> <u>Permit issued 8-8-30</u>		20 REGISTRAR <u>J. E. Tyson</u>		
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____		19 PLACE OF BURIAL OR REMOVAL <u>Int. Goar, Ind.</u> 20 ADDRESS <u>Residing Sun. Ind.</u>		
DATE OF BURIAL <u>Aug 9, 1930</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 2 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE

CORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil md

04159

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 15Village or City Colona (No. 74a)

St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sydia H. Hairland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Dec. 14, 1945  
(Month) (Day) (Year)

7 AGE 84 yrs. 3 mos. 22 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Homemaker  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) New York

10 NAME OF FATHER Daniel P. Hairland

11 BIRTHPLACE OF FATHER (State or country) New York

12 MAIDEN NAME OF MOTHER Akin

13 BIRTHPLACE OF MOTHER (State or Country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Merritt H. Hairland(Address) Colona Md

15 Filed 4-7-1930  
James M. Huntington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 5 (Day) 1930

17 I HEREBY CERTIFY, That I attended the deceased from April 5 1930 to Apr 5 1930  
that I last saw her alive on Apr 5 1930

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage of brain  
(apoplexy)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 1 ds.Contributory  
Secondary

(Signed) Quentin H. H. H. M. D.  
Apr 6 1930 (Address) Liberty Street

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Woodside Cemetery DATE OF BURIAL April 8, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun Md.

16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Unit issued 4-17-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 2 1920

HUBBARD

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Ehlin (No. 135)

0329 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

2 FULL NAME George Hall

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wm 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Unknown, 1853  
(Month) (Day) (Year)

7 AGE 76 yrs. Unknown If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Labourer boy  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Richard Hall

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER No information

13 BIRTHPLACE OF MOTHER (State or Country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Hall  
(Address) Rising Sun Md

15 Filed Jan 20 1930 J. Frank Jones Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 13, 1930 to Jan 19, 1930 that I last saw him alive on Jan 18, 1930, and that death occurred on the date stated above, at 10:40 a.m.  
The CAUSE OF DEATH \* was as follows:  
Myocardial Infarction  
Myocardial degeneration

Contributory Coronary Arteriosclerosis  
Secondary

(Duration) 1 yrs. 1 mos. 1 ds.  
(Signed) H. A. Connelley M. D.  
Jan 19, 1930 (Address) West Nottingham

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 23 yrs. 0 mos. 0 ds. In the all life State all life yrs. 0 mos. 0 ds.

Where was disease contracted, Rising Sun Md if not at place of death?

Former or usual residence Rising Sun Md

19 PLACE OF BURIAL OR REMOVAL West Nottingham DATE OF BURIAL Jan 22, 1930

20 UNDERTAKER J. E. Lyson ADDRESS Rising Sun Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

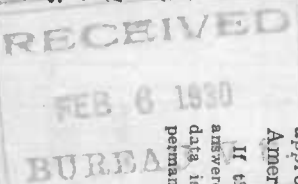
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Village or City

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

05429

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed) M. D.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Permit received 3-3-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 3 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Warrick (No. \_\_\_\_\_)

2 FULL NAME Hanson Hallingworth

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH August 17, 1930  
(Month) (Day) (Year)

7 AGE 1 months 2 2 days 12 hrs. 13 min.  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) Infant

9 BIRTHPLACE (State or country) Warrick Md

10 NAME OF FATHER Engel Hallingworth

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Lambert

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Martha Hallingworth  
(Address) Warrick Md

15 Filed Sept 29 1930 J. Roman  
Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 29, 1930  
(Month) (Day) (Year)

17 9/27 1930 to 9/28 1930  
HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on 9/27, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Marasmus  
Gastro-enteritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) [Signature] M. D.  
(Address) [Address]

\*State the Disease Causing Death, or, Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Augustine Cemetery Oct 1, 1930

20 UNDERTAKER ADDRESS

Sarah Monroe Middleton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archibut, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04157		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Prail</u>			(90)		Registration Dist. No. <u>95</u>	
Village or City <u>Rising Sun</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Cornelia A. Hambleton</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>4</u> <u>25</u> , 19 <u>30</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>August 2</u> , 18 <u>62</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>4/25</u> , 19 <u>30</u> to <u>4/25</u> , 19 <u>30</u> , that I last saw her alive on <u>4/25</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>4:30 a.m.</u>			
7 AGE <u>67</u> yrs. <u>6</u> mos. <u>23</u> ds. or LESS than 1 day _____ hrs. or _____ min.?			The CAUSE OF DEATH * was as follows: <u>Coronary artery disease</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.			
9 BIRTHPLACE (State or country) <u>Maryland</u>			Contributory Secondary (Signed) <u>R. L. Perkins</u> M. D. <u>4/26</u> , 19 <u>30</u> (Address) <u>Prail, Md.</u>			
PARENTS	10 NAME OF FATHER <u>Samuel Win. Lester</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
	12 MAIDEN NAME OF MOTHER <u>Mary E. Murphy</u>		Where was disease contracted, if not at place of death? _____			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		Former or usual residence _____			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>C. E. Hambleton</u> (Address) <u>Rising Sun, Md.</u>						
15 Filed <u>Apr. 26 1930</u> <u>Clara M. Martin</u> Registrar <u>Committee</u> <u>Apr 26 1930</u>			19 PLACE OF BURIAL OR REMOVAL <u>Calvary Friends</u>		DATE OF BURIAL <u>Apr 28, 1930</u>	
			20 UNDERTAKER <u>Clyde E. Mason</u>		ADDRESS <u>Prail, Pa.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

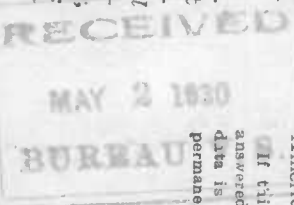
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. . . . . the data is essential and must be obtained before the certificate is permanently filed.



**N. B.--**Every item of information should be carefully supplied. ACE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. **Exact** statement of **OCCUPATION** is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County. Cecil

Village or City El Estero (No. Union Hospital) Ward (If death occurred in hospital institution)

2FULL NAME *Arthur Hamilton*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
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6 DATE OF BIRTH July 19 1924  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than \_\_\_\_\_  
1 day \_\_\_\_\_ hrs.  
yrs. 13 mos. \_\_\_\_\_ ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work.....  
(b) General nature of industry business, or establishment in which employed or (employer).....

9 BIRTHPLACE  
(State or country) 2 0

10 NAME OF FATHER 201 21 25

11 BIRTHPLACE  
OF FATHER  
(State or country) Israel

12 MAIDEN NAME  
OF MOTHER *El. J. J.*

13 BIRTHPLACE  
OF MOTHER  
(State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Hamilton

(Address) North East, Mo

15 Filed Jan 21 1920 Frank Hayes  
Registrar

6330

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
 Jan 16 1930 to Jan 19 1930  
 that I last saw h alive on \_\_\_\_\_, 192\_\_\_\_\_

and that death occurred on the date stated above, at .....m.  
The CAUSE OF DEATH \* was as follows:

Important Dates

(Duration) yrs. mos. 3 da.

Contributory Secondary if existing.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) James J. Kennedy M. D.  
192 \_\_\_\_\_ (Address) 641 17th St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.      In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
-------------------------------	----------------

North East N. F. America, Jan 21, 1930

20 UNDERTAKER	ADDRESS
---------------	---------

Joseph P. Grant North East <sup>not</sup>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WHEN ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Cecil Co.

0331 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

96

Village or City

Port Deposit Md.

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Carl Albert Hanna Jr

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Jan 12, 1930  
(Month) (Day) (Year)

7 AGE

5 yrs. 5 mos. 4 ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none  
none

9 BIRTHPLACE

(State or country)

Port Deposit, Hospital Md

10 NAME OF FATHER

Carl Albert Hanna Sr

11 BIRTHPLACE OF FATHER  
(State or country)

Rising Sun Md

12 MAIDEN NAME OF MOTHER

Elizabeth Francis Cooney

13 BIRTHPLACE OF MOTHER  
(State or country)

Rising Sun Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1/14, 1930 L. Sanders

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 12, 1930, to Jan 12, 1930

that I last saw him alive on , 1930,

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH was as follows:

Still birth do to  
spontaneous rupture  
of membranes  
(Duration) yrs. mos. 2 ds.Contributory  
Secondary

(Signed) Ernest F. Forland  
Jan 13, 1930 (Address) Rising Sun Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cemetery at Home Farm Jan. 14, 1930

20 UNDERTAKER

ADDRESS

Carl A. Hanna Rising Sun, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Congestant," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismus," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1910  
BUREAU V S

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit (No. 129)

05430 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William Harding

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH March 31, 1895  
(Month) (Day) (Year)

7 AGE 35 yrs. 1 mos. 12 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work laborer  
(b) General nature of industry business, or establishment in which employed or (employer) Ward

9 BIRTHPLACE (State or country) South Carolina

10 NAME OF FATHER Tilman Harding

11 BIRTHPLACE OF FATHER (State or country) S. C.

12 MAIDEN NAME OF MOTHER Loggins Phillips

13 BIRTHPLACE OF MOTHER (State or Country) S. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie Hardee

(Address) Boston, Mass

15 Filed May 14, 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 18, 1930 to May 12, 1930

that I last saw him alive on May 12, 1930

and that death occurred on the date stated above, at 12:45 m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
Chronic Endocarditis  
Chronic Parenchymatous Nephritis  
(Duration) 1 yrs. 6 mos. 0 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) G. J. Benson M. D.  
5/14 1930 (Address) Port Deposit, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cokesbury Cem. DATE OF BURIAL May 14, 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Perryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 4 1930  
BUREAU

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Principio Furnace (No. ....)

2 FULL NAME Sarah P. Harkness

07896

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. .... Ward ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb. 22, 1930 (Month) (Day) (Year)

7 AGE 88 yrs. 4 mos. 29 ds. If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Raymond Jackson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Anne Burroughs

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leta Severing

(Address) Principio Furnace, Md.

15 Filed July 23, 1930 L. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 1st, 1929 to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH \* was as follows:

Chromomata

Contributory Secondary

Chronic Valvular Heart Disease (Duration) 6 yrs. mos. ds.

(Signed) F. Magraw M. D. July 22, 1930 (Address) Parnville

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Principio Furnace, Md. July 24, 1930

20 UNDERTAKER ADDRESS

Lee A. Patterson Parnville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 4 1930  
BUREAU V.S.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital) St. 71 Ward 92

2 FULL NAME Harris, Charles

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME in full, street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH August 31, 1929  
(Month) (Day) (Year)

7 AGE 11 yrs. 11 mos. 11 ds. If LESS than 1 day 1 hrs. 1 min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER No Information

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Corrine Hemmley

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record

(Address) Elkton Md.

15 Filed July 23, 1930 W. W. Pippin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 7-7-30 to 7-22-30, 1930

that I last saw him alive on 7-22-30, 1930

and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH was as follows:

Cerebro  
Spinal Hemorrhage  
Non-epidemic Cause, unknown  
Cancer  
(Duration) 11 yrs. 11 mos. 11 ds.

Contributory  
Secondary

(Duration) 11 yrs. 11 mos. 11 ds.  
(Signed) W. W. Pippin M.D.  
3-21-30 Address Elkton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 11 yrs. 11 mos. 11 ds. In the State 11 yrs. 11 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

County Burial Cemetery July 23, 1930

20 UNDERTAKER ADDRESS N. W. Pippin Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

Village or City Rising Sun (No. \_\_\_\_\_)

2 FULL NAME Dalton Harris Jr.

09124 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 40

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Aug 5, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day 57 hrs.  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Dalton Harris

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Ada Underwood

13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dalton Harris

(Address) Rising Sun Ind.

15 Filed 8-6 1930

Permit issued 8-6-1930

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 5, 1930 to Aug 5, 1930  
that I last saw him live on Aug 5, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Infant, undeveloped.

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) F. P. Swygard M. D.  
Aug 6, 1930 (Address) 11 Dardington Ave

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Hattingsham Ind. DATE OF BURIAL Aug 6, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 2 1930  
BUREAU V S

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil

13698

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City Elkton R.F.D. No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dolly Mae Harris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Oct111930

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

29 ds.If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

md

10 NAME OF FATHER

Lomis J. Harris

11 BIRTHPLACE OF FATHER

(State or country)

S. C

12 MAIDEN NAME OF MOTHER

Emma Smith

13 BIRTHPLACE OF MOTHER

(State or Country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lomis J. Harris

(Address)

Elkton R.F.D. #4

15 Filed

11-9-30

192

11-9-30

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11-9-30

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 81930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

OCT 291930to Nov 81930that I last saw her alive on November 7, 1930,and that death occurred on the date stated above, at 4 A. m.

The CAUSE OF DEATH \* was as follows:

marasmus caused by congenital debility.

(Duration)

yrs.

mos. 29 ds.Contributory  
SecondaryBubinitis

(Duration)

yrs.

mos. 8 ds.

(Signed)

F. G. Miller

M. D.

Nov. 81930

(Address)

Elktonmd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

North East M. E. CemeteryNov 9, 1930

20 UNDERTAKER

ADDRESS

Joseph R. ShawNorth East md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City near Bay View No. \_\_\_\_\_

2 FULL NAME William H. Harris

04158 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 4, 1841  
(Month) (Day) (Year)

7 AGE 88 yrs. 4 mos. 8 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) not known

10 NAME OF FATHER Samuel Harris

11 BIRTHPLACE OF FATHER (State or country) not known

12 MAIDEN NAME OF MOTHER Elizabeth Shier

13 BIRTHPLACE OF MOTHER (State or Country) not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm Harris  
(Address) North East RD #1 Md

15 Filed 4-15-30 E. W. Owens  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 25, 1930 to 4-12, 1930, that I last saw him alive on 4-12, 1930

and that death occurred on the date stated above, at 7 p.m.

The CAUSE OF DEATH \* was as follows:  
Enteritis  
Central  
peritonitis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_ Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Alfred G. Rogers M. D.  
4-14, 1930 Address See Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rosebank Cemetery, Calverton Apr 16, 1930

20 UNDERTAKER ADDRESS

Joseph R. Grant

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescal; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescal (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

02817

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Elkton

(No.

R.D.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

James Harshaw

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb 9

(Month)

(Day)

1859 (Year)

7 AGE

71

yrs.

1 mos.

2 ds.

IF LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Ireland

10 NAME OF FATHER

David Harshaw

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Matthews

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Harshaw

(Address)

Elkton Rd RD

15 Filed

March 12 1930 J. Frank Jones Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 11<sup>th</sup>

1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1<sup>st</sup> 1930 to March 11<sup>th</sup> 1930, that I last saw him alive on March 11<sup>th</sup> 1930,

and that death occurred on the date stated above, at 6:30 p.m. The CAUSE OF DEATH was as follows:

Chronic myocarditis

(Duration) 1 yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) J. Frank Jones M. D.

192

(Address)

Elkton

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

March 13, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Rd

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus; *Farmer (retired, 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1920  
BUREAU OF



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Colora (No. \_\_\_\_\_)

2 FULL NAME John Boyd Hawley

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 14, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 6 mos. 3 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Montgomery County, Va.

10 NAME OF FATHER Boyd Hawley

11 BIRTHPLACE OF FATHER (State or country) Montgomery County, Va.

12 MAIDEN NAME OF MOTHER Susan Cooper

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Hawley

(Address) Colora, Md.

15 Filed Jan 20 1930  
James M. Worthington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1-11-30 to 1-18-30, 1930

that I last saw him alive on 1-17, 1930

and that death occurred on the date stated above, at 6 A. m.

The CAUSE OF DEATH \* was as follows:

Hemiplegia  
Arteriosclerosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Reed Dooley (M. D.)  
1-18-30 (Address) Being Sent

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Puthingham DATE OF BURIAL Jan 20, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Residing in Md.

Permit issued 1-20-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1930

BUR

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil Co.

Village or City Port Deposit

2 FULL NAME Carolyn Phoebe Hayes

13699  
148  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 35

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Aug. 21, 14  
(Month) (Day) (Year)

7 AGE 16 yrs. 3 mos. 4 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Laureate, Co. Penn

10 NAME OF FATHER Howard Hayes

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER H. Jennie Hess

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Hayes

(Address) Port Deposit, Ind.

15 Filed 11/26 1930  
John E. Tyson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov - 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 24, 1930 to Nov 25, 1930  
that I last saw her alive on Nov 25, 1930

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH \* was as follows:

Post Partum Eclampsia  
(Acute Nephritis)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) B. J. Benson M.D.

11/25 1930 (Address) Port Deposit, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Little Britain, Pa

DATE OF BURIAL Nov 28, 1930

20 UNDERTAKER J. E. Tyson

ADDRESS Rising Sun, Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 11-26-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Appleton (No. \_\_\_\_\_)

2 FULL NAME William R. E. Hayes

12334

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 99

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 11, 1944  
(Month) (Day) (Year)

7 AGE 86 yrs. — mos. 19 ds. or min.?  
If LESS than 1 day.....hrs.

OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert M. Hayes

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza J. Evans

13 BIRTHPLACE OF MOTHER (State or Country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Abel Jr

(Address) Childs, Md RD 1

15 Filed Nov 1, 1930 J. Paul J. Jans  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct - 30 - 1930  
(Month) 30 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11-1-1929 to 10-30-1930, that I last saw him alive on 10-29-1930

and that death occurred on the date stated above, at 4 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
myocard Regurg.  
(Duration) 1 yrs. 1 mos. 1 ds.

Contributory Secondary Same

(Signed) L. B. Welch M. D.  
10-31-1930 (Address) Newark Del

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recant Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Cherry Hill Cemetery DATE OF BURIAL Nov 2nd, 1930

20 UNDERTAKER G. J. Chemnitz ADDRESS Certox, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., (*Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930  
BUREAU V S

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

Village or City

North East, Md. R.D. (No. \_\_\_\_\_)

2 FULL NAME

Margaret Heath

07898

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

94

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Jan, 13, 1866  
(Month) (Day) (Year)

7 AGE

64 yrs. 7 mos. 1 ds. or min.?

If LESS than  
1 day... hrs.  
1 day... hrs.  
1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

J. Daugherty

11 BIRTHPLACE OF FATHER

(State or country)

No information

12 MAIDEN NAME OF MOTHER

Martha Mahoney

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. B. Heath

(Address)

Wilmington, Del. R.D.

15

Filed 7-17-30 192

Geo W. Quinn

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 30 to July 15, 1930

that I last saw him alive on July 15, 1930 and that death occurred on the date stated above, at 7:30 P.M. The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

Contributory  
Secondary

(Duration) 10 yrs. mos. ds.

Cerebral Apoplexy

(Signed)

J. B. Cunningham

M. D.

July 17, 1930 (Address) North East, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Cherry Hill Cemetery

DATE OF BURIAL

July 18, 1930

20 UNDERTAKER

A. J. Chumack

ADDRESS

Belting, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 2 1930

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## 1 PLACE OF DEATH

County Cecil

05431

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME HEBRANK, Joseph F. M. C-1 099 628

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH <u>October 16, 1893.</u> (Month) (Day) (Year)
---

7 AGE <u>36 yrs. 6 mos. 16 ds.</u> or min.?	IF LESS than 1 day ____ hra. or ____ min.?
---	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Post-Office Clerk.</u> (b) General nature of industry, business, or establishment in which employed or (employer)
---

9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u>
---

10 NAME OF FATHER <u>Michael Hebrank</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>
--

12 MAIDEN NAME OF MOTHER <u>Mary Klump</u>
---

13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records,(Address) Perry Point, Md.15 Filed May 15, 1930 Charles D. Morrison  
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>May 15, 1930.</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from  
November 4, 1927. to May 15, 1930.that I last saw him alive on May 15, 1930.and that death occurred on the date stated above, at 10:55 A.M.

The CAUSE OF DEATH \* was as follows:

Tuberculosis, Pulmonary, chronic, advanced, active Type C.(Duration) 1 yrs. 3 mos. ds.Contributory Dementia Praecox, Hebeephrenic  
Secondary Type, pronounced (Duration) 5 yrs. mos. ds.(Signed) W. A. Billison M. D.  
W. A. BILLISON, Acting Med. Officer in Ch.  
May 15, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 10 mos. 17 ds. In the State Unknown ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 910 N. Eden St., Balto., Md.

19 PLACE OF BURIAL OR REMOVAL <u>Henry Mears &amp; Son, 805 N. Calvert St., Balto., Md.</u>	DATE OF BURIAL <u>May 17, 1930.</u>
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20 UNDERTAKER <u>Pennington &amp; Son, Havre de Grace, Md.</u>	ADDRESS <u>Pennington</u>
---	------------------------------

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Printer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drugs," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be completed before the certificate is permanently filed.

RECEIVED MAY 26 1930 U. S. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		01534		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u> (No. <u>100-a</u> )		St. <u>      </u> Ward <u>      </u>		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Walter Edward Hiers</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Feb. 27 1928</u> (Month) (Day) (Year)					
7 AGE <u>11</u> yrs. <u>11</u> mos. <u>11</u> ds. or LESS than 1 day <u>      </u> hrs. <u>      </u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>      </u>					
9 BIRTHPLACE (State or country) <u>New Jersey</u>					
10 NAME OF FATHER <u>Edward Hicks</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>New Jersey</u>					
12 MAIDEN NAME OF MOTHER <u>Bear Herrick</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Bear Hicks</u> (Address) <u>Port Deposit Ind.</u>					
15 Filed <u>2/9</u> 19 <u>30</u> <u>L. Sanders</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 7 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 1 1930</u> to <u>July 7 1930</u> that I last saw him alive on <u>July 6 1930</u> and that death occurred on the date stated above, at <u>12</u> m. The CAUSE OF DEATH * was as follows: <u>Pneumonia</u> (Duration) <u>4</u> yrs. <u>      </u> mos. <u>      </u> ds. Contributory <u>      </u> Secondary <u>      </u> (Signed) <u>W. J. Jackson</u> M. D. <u>July 8 1930</u> (Address) <u>Port Deposit Ind.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, if not at place of death? <u>      </u> Former or usual residence <u>      </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Port Deposit Cem.</u>				DATE OF BURIAL <u>Feb. 10 1930</u>	
20 UNDERTAKER <u>Lee A. Patterson</u>				ADDRESS <u>Port Deposit Ind.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PARENTS

1 PLACE OF DEATH County <u>Cecil</u>		13700 (74-a)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. ....)		St. ....		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Annie C Hitchen</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widowed</u> (Write the word)			
6 DATE OF BIRTH <u>Apr 23</u> , 18 <u>51</u> (Month) (Day) (Year)					
7 AGE <u>79</u> yrs. <u>6</u> mos. <u>27</u> ds. or LESS than 1 day ____ hrs. ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>New York</u>					
10 NAME OF FATHER <u>Cornelius McGready</u>					
11 BIRTHPLACE OF FATHER <u>Ireland</u> (State or country)					
12 MAIDEN NAME OF MOTHER <u>Annie McLean</u>					
13 BIRTHPLACE OF MOTHER <u>Ireland</u> (State or Country)					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo Hitchen</u> (Address) <u>Elkton Md</u>					
15 Filed <u>Nov 22 1930</u> <u>Frank D. Bazz</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 20</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 15</u> , 192 <u>9</u> , to <u>Nov 20</u> , 19 <u>30</u> , that I last saw her alive on <u>Nov 19</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>29</u> m. The CAUSE OF DEATH * was as follows: <u>Cerebral apoplexy</u>					
(Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary <u>arterio sclerosis</u>					
(Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u>Herbert B. Bates</u> M. D. <u>11/21</u> 19 <u>30</u> (Address) <u>Elkton Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Catholic Cemetery</u>				DATE OF BURIAL <u>Nov 22</u> , 19 <u>30</u>	
20 UNDERTAKER <u>W. W. Pippin</u>				ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
DEC 5 1930  
BUREAU

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

0333 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Anne Hitehus

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept 17, 1869  
(Month) (Day) (Year)

7 AGE 60 yrs. 3 mos. 28 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Maskee

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Kershaw

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morris Hitehus

(Address) Elkton Md

15 Filed Jan 16, 1930 J. Pauls Gray Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 27, 1929 to Jan 15, 1930

that I last saw him alive on Jan 14, 1930

and that death occurred on the date stated above, at 5.50 am.

The CAUSE OF DEATH \* was as follows:

Chronic interlobular cirrhosis of liver  
(Duration) 2+ yrs. mos. ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. mos. ds.  
(Signed) V. H. McKnight M. D.  
Jan 15, 1930 (Address) Elkton, Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cherry Hill Cemetery DATE OF BURIAL Jan 18, 1930

20 UNDERTAKER A. J. Chemsathy ADDRESS Elkton, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Eckton (No. \_\_\_\_\_)

2 FULL NAME Winfield Raymond Hitchcock

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 26, 1930  
(Month) (Day) (Year)

7 AGE 23 yrs. — mos. — ds. or — min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Irvin S. Hitchcock

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Reba Goodger

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irvin S. Hitchcock

(Address) Eckton Md

15 Filed July 20, 1930 J. Francis Trager  
Registrar

07899

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 19, 1930 to July 19, 1930

that I last saw him alive on July 19, 1930

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

Enterocolitis

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 10 ds.

(Signed) W. D. Morris M. D.  
July 20, 1930 (Address) Eckton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East Cemetery DATE OF BURIAL July 20, 1930

20 UNDERTAKER G. J. Akematty ADDRESS Eckton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

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WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit (No. 74a)

2 FULL NAME Tolerous N. Kite

02818 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 18, 1875  
(Month) (Day) (Year)

7 AGE 54 yrs. 5 mos. 22 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER John Kite

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Solladay

13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Myrtle Kite  
(Address) Port Deposit Md.

15 Filed Dec 24 - 1930 Registrar James M. Nottingham

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 3/22, 1930  
that I last saw him alive on \_\_\_\_\_, 1930

and that death occurred on the date stated above, at 12:10 m.

The CAUSE OF DEATH \* was as follows:

From information:  
central hemorrhage  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_ 1930 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  
Green (Coroner)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Nottingham, Md. Mar 25, 1930

20 UNDERTAKER ADDRESS

J. E. Tyson. Rising Sun, Md.

Permitted 3-24-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930

BUREAU OF



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

06608

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 72

Village or City Elkton R.D. 1 (No. 1)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Talitha Mahoney Holden

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Feb 13, 1839  
(Month) (Day) (Year)

7 AGE 91 yrs. 4 mos. 21 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. Mahoney

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Haniet Mahoney

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dori B. Holden  
(Address) Elkton, Md R.D. 1

15 Filed June 16 1930 J. Paul Jager  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 5 1920 to June 15, 1920, that I last saw him alive on June 15, 1920.

and that death occurred on the date stated above, at 1230 P. m.  
The CAUSE OF DEATH \* was as follows:

Senile dementia

(Duration) 3 yrs. 3 mos. 3 ds.  
Contributory Arterio Sclerosis  
Secondary \_\_\_\_\_

(Duration) 10 yrs. 10 mos. 10 ds.  
(Signed) Dr. P. Harrison M. D.  
June 14 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East Cemetery DATE OF BURIAL June 18, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 8 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Cecil*

07900

(49)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*72*

Village or City

*Elkton*

(No. \_\_\_\_\_)

*Union Hospital*

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Nicholas Holmes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M.*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Widowed*

6 DATE OF BIRTH

*March**19**1853*

(Month)

(Day)

(Year)

7 AGE

*77* yrs.*3* mos.*14* ds.

If LESS than

1 day \_\_\_\_ hrs.

or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Labor*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Maryland*

10 NAME OF FATHER

*No Information*

11 BIRTHPLACE OF FATHER

*SS*

12 MAIDEN NAME OF MOTHER

*Mary Bussie*

13 BIRTHPLACE OF MOTHER

*No Information*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Union Hospital*

(Address)

*Elkton Md.*

15

Filed

*July 7 1930**Frank J. Jager*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 3**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov**1929*

to

*July 3**1930*

that I last saw him alive on

*July 3**1930*

and that death occurred on the date stated above, at

*Elkton Md.*

The CAUSE OF DEATH \* was as follows:

*Carcinoma of prostate gland*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*Herbert Bales*

M. D.

*July 4**1930*

(Address)

*Elkton Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

*8* mos.*27* ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*Elkton Md*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Elkton Cemetery**July 7, 1930*

20 UNDERTAKER

ADDRESS

*R. W. Pippin**Elkton Md.*

# CERTIFICATE OF DEATH

U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary afection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, telanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

02819 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

July 3, 1862

7 AGE

67 yrs. 8 mos. 22 ds. or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Jesse K. Simpkins

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ellen Boulton

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Howard Jones

(Address)

Elkton 2nd Rd

15

Filed

March 26, 1930 J. J. Parks, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 15, 1920

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1, 1920 to March 15, 1920 that I last saw him alive on March 15, 1920

and that death occurred on the date stated above, at 7:00 p.m. The CAUSE OF DEATH \* was as follows:

Chronic myocarditis

Contributory Secondary

(Duration) yrs. mos. ds.

Chronic myocarditis

(Signed)

J. J. Parks, Jr. M. D.

1920 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Union Cemetery 2nd Co

DATE OF BURIAL

March 28, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton 2nd

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 5 1900

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME Louisa Homberger

02820

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH June 11, 1850  
(Month) (Day) (Year)

7 AGE 79 yrs. 8 mos. 23 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Benjamin B. Booth

11 BIRTHPLACE OF FATHER (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Elizabeth Byron

13 BIRTHPLACE OF MOTHER (State or Country) Liverpool England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Homberger

(Address) Perryville, Md.

15 Filed 3/8/1930 W. F. Sanders Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 6, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 15th 1930 to March 6, 1930, that I last saw her alive on March 5, 1930

and that death occurred on the date stated above, at 4 a. m.  
The CAUSE OF DEATH \* was as follows:

Atheromata

Contributory (Duration) 15 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Secondary Cerebral Haemorrhage

(Signed) J. F. Magruder M. D. 3/6/1930 (Address) Perryville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Asbury Cem. DATE OF BURIAL March 9, 1930

20 UNDERTAKER Lee H. Patterson ADDRESS Perryville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			10295		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(31)		Registration Dist. No. <u>96</u>	
Village or City <u>Port Deposit</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>William J. Hopkins</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>Jan 16</u> , 1882 (Month) (Day) (Year)						
7 AGE <u>48</u> yrs. <u>7</u> mos. <u>20</u> ds. or LESS than 1 day _____ hrs. _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Day</u>						
9 BIRTHPLACE (State or country) <u>Md.</u>						
PARENTS						
10 NAME OF FATHER <u>Benjamin F. Hopkins</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>						
12 MAIDEN NAME OF MOTHER <u>Mary Bladen</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah P. Hopkins</u> (Address) <u>Port Deposit Md.</u>						
15 Filed <u>9/7</u> , 192 <u>3</u> <u>L. F. Sanders</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Sept-5</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July</u> , 19 <u>30</u> to <u>Sept 4</u> , 19 <u>30</u> that I last saw him alive on <u>Sept 4</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>7:30</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) _____ yrs. _____ mos. _____ ds.						
Contributory Secondary (Signed) <u>B. B. Brown</u> M. D. <u>9/6</u> , 19 <u>30</u> (Address) <u>Port Deposit Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Mt Zion Church</u> DATE OF BURIAL <u>8</u> , 19 <u>30</u>						
20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Cerryville Md.</u>						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1930

BUREAU



WRITE QUICKLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City Edgemoor (No. Union Hospital)2 FULL NAME Stephen HornerSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92St. Edgemoor Ward Union Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED no information  
(Write the word)

6 DATE OF BIRTH no information, 1902  
(Month) (Day) (Year)

7 AGE 28 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) no information

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (State or country) —

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Union Hospital record(Address) Edgemoor 2nd

15 Filed Apr 16 1920 J. Frank Hayes  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 27 1920 to April 8, 1920  
that I last saw him alive on April 8, 1920

and that death occurred on the date stated above, at 8 a m.  
The CAUSE OF DEATH \* was as follows:

Toxemia (Streptococci)  
(Duration) 4 yrs. 0 mos. 0 ds.

Contributory Secondary —  
(Duration) 12 yrs. 0 mos. 0 ds.

(Signed) V. H. Mc Knight M. D.  
April 8 1920 (Address) Edgemoor 2nd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 11 yrs. 0 mos. 0 ds. In the State 11 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cecil Co. Md.

19 PLACE OF BURIAL OR REMOVAL County Home Cemetery DATE OF BURIAL Apr 16, 1920

20 UNDERTAKER H. W. Payne ADDRESS Edgemoor 2nd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Intuition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Village or City

(No.)

FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than  
1 day.....hrs.  
1 day.....hrs.  
yrs.....7 mos. 19 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

20

27

1930

J. Frank Gray

Registrar

01535

90

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos. 1 ds. In the State.....yrs.....mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1910  
BUREAU V. S.

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1 PLACE OF DEATH  
County Beech

Village or City Eckton (No. 7)

2 FULL NAME Jane Elizabeth Hunt

09125

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH

Mar 21, 1930  
(Month) (Day) (Year)

7 AGE

5 yrs. 5 mos. 9 ds. or 1 day 0 hrs. 0 min. If LESS than 1 day

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Liefield Hunt

11 BIRTHPLACE OF FATHER

(State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Anna Hunt

13 BIRTHPLACE OF MOTHER

(State or Country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Liefield Hunt  
Eckton, Md

15

Filed

Apr 1<sup>st</sup> 1930 J. Frank Bager  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 30, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

August 26, 1930 to Aug 30, 1930

that I last saw him alive on Aug 29, 1930

and that death occurred on the date stated above, at 245 a m.

The CAUSE OF DEATH \* was as follows:

Acute Ilio colitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Herbert Bales M. D.  
830 30 (Address) Eckton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Eckton Cemetery Apr 1, 1930

20 UNDERTAKER

ADDRESS

C. V. Coker Eckton, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			13701		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(46)		Registration Dist. No. <u>95</u>	
Village or City <u>Rowlandville Md.</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Anna Clara Huss</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		16 DATE OF DEATH <u>Nov 23, 1920</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Mar 17, 1874</u> (Month) (Day) (Year)				17 I HEREBY CERTIFY, That I attended the deceased from <u>May 20, 1920</u> to <u>Nov 23, 1920</u> , that I last saw him alive on <u>Nov 22, 1920</u> , and that death occurred on the date stated above, at <u>3.30 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Carcinoma of uterus</u>		
7 AGE <u>56 yrs. 8 mos. 5 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Rowlandville Md.</u>						
10 NAME OF FATHER <u>Thomas Alexander</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Rowlandville Md.</u>						
12 MAIDEN NAME OF MOTHER <u>Rebecca Founds</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alonzo A. Hewes</u> (Address) <u>Spomwings Md.</u>						
15 Filed <u>11 20 1920</u> <u>Lorinda M. McWhorter</u> Registrar				19 PLACE OF BURIAL OR REMOVAL <u>Cabwood Md.</u> 20 UNDERTAKER <u>L. E. Tyson</u> ADDRESS <u>Rising Sun Md.</u>		
16 DATE OF BURIAL <u>Nov 25, 1920</u>						

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

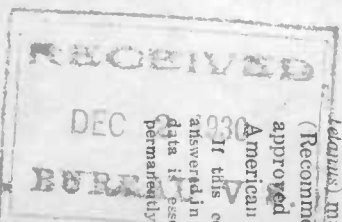
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (1: only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, delirium*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Corrected copy.

1 PLACE OF DEATH  
County Cecil

07901 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton, Md. (No. Union Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Wilmer (Chase) Hutchinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 27th, 1888  
(Month) (Day) (Year)

7 AGE 41 yrs. 10 mos. 23 ds. or IF LESS than 1 day hrs. 23 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Richard Hutchinson,

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mollie Milburn.

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Gorden,  
(Address) Elkton, Md.

15 Filed July 22 1920 J. Frank Jester  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20th, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 15th, 1920 to July 20th, 1920, that I last saw him alive on July 19th, 1920, and that death occurred on the date stated above, at 5:30 A.

The CAUSE OF DEATH \* was as follows:  
General peritonitis from rupture of prostatic abscess.

(Duration) 9 yrs. 5 mos. 5 ds.  
Contributory Fresh fistula - after 3rd attempt to close same (Duration) 10 yrs. 10 mos. 10 ds.

(Signed) V. H. McJannet M. D.  
July 21, 1920 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 9 yrs. 9 mos. 9 ds. In the State 9 yrs. 9 mos. 9 ds.  
Where was disease contracted, if not at place of death? Elkton, Maryland.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Elkton Colored Cemetery July 22 30  
20 UNDERTAKER ADDRESS

H. W. Pippin Elkton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

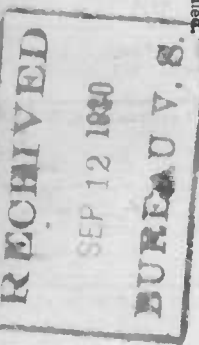
**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REC'D

7-1930





PLACE OF DEATH

County

Cecil

06609

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Ehlers

(No.

Union Heights

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Harry Bradley Hutton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

May 6,

(Month)

(Day)

1879  
(Year)

7 AGE

31

yrs.

1

mos.

19

ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Chemist

(b) General nature of industry business, or establishment in which employed or (employer)

Retired

9 BIRTHPLACE

(State or country)

Wilmington

10 NAME OF FATHER

John Hutton

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Ellen Bradley

13 BIRTHPLACE OF MOTHER

(State or Country)

England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. A. C. Hutton

(Address)

North East Md

15

Filed June 25 1920

F. H. Hutton

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 25, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

May 1,

1930

to

June 25,

1930

that I last saw him alive on

June 25,

1930

and that death occurred on the date stated above, at 10:30 A.M.  
The CAUSE OF DEATH \* was as follows:Rheumatism, Chronic  
DiagnosisContributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

H. A. C. Hutton

M. D.

June 25,

1930

(Address)

North East Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

1

ds.

In the State

30

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Charleston Md

Former or usual residence

Charleston Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Salem M. E. Cemetery

June 27,

1930

20 UNDERTAKER

Joseph R. Hutton

ADDRESS

North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Ceis

07962

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City

Perryville

(No.)

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Andrew Columbus Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write in full)

Married

6 DATE OF BIRTH

June 26, 1854

(Month)

(Day)

(Year)

7 AGE

76 yrs. 12 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

Retired

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Andrew C. Jackson

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Florence Calvert

(Address)

Perryville, Md.

15

Filed

1927

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended the deceased from

Apr. 1st 1930 to July 6, 1930

that I last saw him alive on July 3, 1930

and that death occurred on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH \* was as follows:

Supine Tubercular  
Heart Disease

(Duration) 3

yrs. mos. ds.

Contributory  
Secondary

Atheromata

(Duration)

yrs. mos. ds.

(Signed)

J. F. Magraw M. D.

July 7, 1930 (Address) Perryville

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Middle River, Balto.

DATE OF BURIAL

20 UNDERTAKER

Lee A. Patterson Perryville

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; L. pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Pottersdale (No. 74a)

2 FULL NAME Josephine Jackson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female  
4 COLOR OR RACE White  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 6, 1844  
(Month) (Day) (Year)

7 AGE 86 yrs. 4 mos. 20 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House work  
(b) General nature of industry business, or establishment in which employed or (employer) at home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Correll

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. B. Correll  
(Address) Perryville, Md.

15 Filed July 27, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 10, 1929 to July 26, 1930, that I last saw her alive on July 20, 1930

and that death occurred on the date stated above, at 11 m.  
The CAUSE OF DEATH \* was as follows:

Thrombosis  
(Duration) 10 yrs. mos. ds.

Contributory Secondary Apoplexy

(Signed) J. F. Magraw M. D.  
July 27, 1930 (Address) Perryville, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
Hobbeswell Ave. July 27, 1930

20 UNDERTAKER Lee A. Pitterson Perryville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 4  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

07904

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Perry Point (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Unknown 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE About 24 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Elevator  
(b) General nature of industry, business, or establishment in which employed or (employer) Operator

9 BIRTHPLACE (State or country) South Carolina

10 NAME OF FATHER Samuel Jackson

11 BIRTHPLACE OF FATHER S.C.  
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Brice

13 BIRTHPLACE OF MOTHER S.C.  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen Jackson(Address) 1436 Catherine St

15 Filed July 4 1930 L. Sanders Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 22 1930 to July 3, 1930,  
that I last saw him alive on July, 1930,

and that death occurred on the date stated above, at 2:40 a.m.  
The CAUSE OF DEATH \* was as follows:

Tuberculosis, Pulmonary,  
Chronic, far advanced

(Duration) unknown yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Edward Schenck M. D.  
July 4<sup>th</sup> 1930 (Address) Perry Point, Md.

\* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Rock Hill, S.C.

19 PLACE OF BURIAL OR REMOVAL Rock Hill S.C. DATE OF BURIAL July 6, 1930

20 UNDERTAKER R. Madison Mitchell ADDRESS Hardegrave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

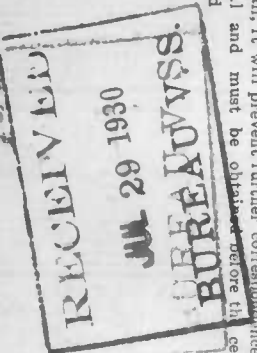
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed



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1 PLACE OF DEATH  
County Cecil

Village or City Pikins (No. \_\_\_\_\_)

2 FULL NAME Samuel Henry Jackson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH May 29, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 28 mos. 25 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Harry Jackson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Letitia McDevonshire

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Jackson  
(Address) Pikins, Md.

15 Filed Oct 30 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28<sup>th</sup>, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from Oct 23<sup>rd</sup>, 1930, to Oct 28<sup>th</sup>, 1930.

that I last saw him alive on Oct 28<sup>th</sup>, 1930.

and that death occurred on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH \* was as follows:

Acute Cholera Infantum  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. J. Magraw, M. D.  
Oct 29 1930 (Address) Werryville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Asbury Cem. DATE OF BURIAL Oct 30, 1930

20 UNDERTAKER Leila Pittman ADDRESS Bryndale, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
NOV 5 1930  
BUREAU



WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County  Cecil

Village or City  Elkton  (No.  RD )

2 FULL NAME  Emma B. Jaguette

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Female  4 COLOR OR RACE  white  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  Single

6 DATE OF BIRTH  June 24 , 18 65   
(Month) (Day) (Year)

7 AGE  64  yrs.  4  mos.  28  ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  At Home   
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)  Maryland

10 NAME OF FATHER  Robt Jaguette

11 BIRTHPLACE OF FATHER (State or country)  Delaware

12 MAIDEN NAME OF MOTHER  Martha J Bristow

13 BIRTHPLACE OF MOTHER (State or Country)  Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  Clinton Jaguette   
(Address)  Elkton Md RD

15 Filed  Feb 22 1930   J. Frank Jones  Registrar

01536

(14-2)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.  92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  February 22 , 19 30   
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  June  192 7  to  Feb 22 , 19 30 ,  
that I last saw her alive on  Feb 22 , 19 30 ,

and that death occurred on the date stated above, at  11:50 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Apoplexy

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.  4  ds.  
Contributory  Arterio Sclerosis   
Secondary

(Duration)  3  yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed)  Hubert Bales  M. D.  
 2/24  19 30  (Address)  Elkton Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL  Cherry Hill Cemetery  DATE OF BURIAL  Feb 26 1930

20 UNDERTAKER  H. W. Pippin  ADDRESS  Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village <u>Perry Point</u> (No. <u>11-2</u> )		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>William E. James</u>		St. <u>      </u> Ward <u>      </u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)	
6 DATE OF BIRTH <u>Nov 1, 1856</u> (Month) (Day) (Year)			
7 AGE <u>73</u> yrs. <u>6</u> mos. <u>3</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Labo</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>John James</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Jane James</u>		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>Robert Taylor</u>			
(Address) <u>Harris de Grace Rd</u>			
15 Filed <u>June 7, 1930</u> <u>I. L. Sanders</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>June 4th, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 3rd, 1930, to June 4th, 1930,</u> that I last saw him alive on <u>June 3rd, 1930,</u> and that death occurred on the date stated above, at <u>1 PM</u> m. The CAUSE OF DEATH * was as follows: <u>Influenza</u>			
(Duration) <u>      </u> yrs. <u>10</u> mos. <u>10</u> ds.			
Contributory Secondary <u>Bacterial Pneumonia</u>			
(Signed) <u>A. W. Steiner</u> M. D.			
<u>6-5</u> 19 <u>30</u> (Address) <u>Harris de Grace</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence <u>      </u>			
19 PLACE OF BURIAL OR REMOVAL <u>St. Ann's Cemetery</u>		DATE OF BURIAL <u>June 7, 1930</u>	
20 UNDERTAKER <u>Reverend J. D. H. de Grace</u>		ADDRESS <u>Harris de Grace</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 3 1930

BUR

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME David Henderson Jenkins

02821

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Aug 15, 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 7 mos. 12 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Penn

10 NAME OF FATHER George Jenkins

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Susan Thomas

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. David H. Jenkins

(Address) Rock Springs Pa

15 Filed March 20 1930 J. Zamb Zager  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 26, 1930, to March 27, 1930, that I last saw him alive on March 27, 1930, and that death occurred on the data stated above, at 1:30 P. M.. The CAUSE OF DEATH \* was as follows:

acute cardiac dilatation

Contributory Secondary degeneration of stomach  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) John J. Glavin M. D.  
1930 (Address) Celpha

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rock Springs Pa

DATE OF BURIAL

March 30, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 5 1930

BUREAU V. 8

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		14865		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>134 E High</u> )		St. _____ Ward _____		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Miscanaggi Jensen</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>			
6 DATE OF BIRTH <u>Dec 13 1930</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day - hrs. or 20 min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Elkton Md.</u>					
10 NAME OF FATHER <u>Fred. John Jensen</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>					
12 MAIDEN NAME OF MOTHER <u>Mabel McKeimney</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Fred. John Jensen</u> (Address) <u>Elkton Md.</u>					
15 Filed <u>Dec 14</u> 19 <u>30</u> <u>J. M. T. T. T.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Dec 13 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 13 1930</u> to <u>Dec 13 1930</u> , that I last saw her alive on <u>Dec 13 1930</u> , and that death occurred on the date stated above, at <u>11:05 A</u> m. The CAUSE OF DEATH * was as follows: <u>Premature delivery</u> <u>4 1/2 mos gestation</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Herbert G. Gals</u> M. D. <u>12/14 1930</u> (Address) <u>Elkton Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>North East Cemetery</u>				DATE OF BURIAL <u>Dec 17 1930</u>	
20 UNDERTAKER <u>H. W. Phipps</u>				ADDRESS <u>Elkton Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solomon, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1901  
BUREAU A. S.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME John M. Johnson

02822  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 7th, 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 10 mos. 26 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Ethelene Tyson

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellsworth Johnson

(Address) 136 Bridge St. Elkton

15 Filed March 5 1930 J. Frank Hays Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 3rd, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,  
that I last saw him alive on 3/3, 1930.

and that death occurred on the date stated above, at 1:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Acute Cardiac  
Deilitation

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_, 192 (Address)

\*State the cause of death, or, in deaths from violent causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.  
Left Green (Colon)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Franklin Cemetery Mar 6, 1930

20 UNDERTAKER

ADDRESS

G. J. Abernathy Elkton md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

0334 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 914

Village or City North East (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lydia C. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 23, 1876  
(Month) (Day) (Year)

7 AGE 73 yrs. 6 mos. 11 ds. or min.? If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Jethro Johnson

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Ann Winchester

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Johnson

(Address) North East md

15 Filed 1-7-30 192 Geo W. Owens  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 6, 1929 to Jan 4, 1930  
that I last saw her alive on Jan 2, 1930

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH \* was as follows:

Chronic Bronchitis  
(Senility)  
(Duration) 10 yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) C. P. Owens M. D.  
Jan 6, 1930 (Address) North East, md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, yrs. .... mos. .... ds. In the State, yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bayview M. P. Cemetery DATE OF BURIAL Jan 7, 1930  
20 UNDERTAKER Joseph P. Shaw ADDRESS North East md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "De-laver," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-work*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A 1th data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1920

DEPT. OF HEALTH

MARGIN RESERVED FOR BINDING

WRITE ALWAY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Edelton (No. \_\_\_\_\_)

2 FULL NAME Baby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Dec. 23rd, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Union Hg. Edelton Md.

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (State or country) Ky.

12 MAIDEN NAME OF MOTHER Clara Christopher

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Christopher

(Address) same

15 Filed Dec 26 1930 J. Frank Hayes Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 23rd, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_\_\_ to \_\_\_\_\_ 192\_\_\_\_,

that I last saw him alive on \_\_\_\_\_ 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Stillborn  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. McHugh M. D. Dec 24 1930 (Address) Edelton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parents at Home \_\_\_\_\_, 19\_\_\_\_

20 UNDERTAKER ADDRESS

No

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc.; Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, peritonitis, etc.*" State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 7 1931

BUREAU

WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit P.D. (No. 74a)

05432 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

2 FULL NAME Addie E. Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH April, 21, 1869  
(Month) (Day) (Year)

7 AGE 61 yrs. 14 mos. 14 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed or (employer) at home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James W. Lipton

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha M. Francis

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Nesbitt  
(Address) Port Deposit, Md. P.D.

15 Filed 5/7 1930 L. B. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 3rd, 1930, to May 5, 1930.

that I last saw her alive on May 5, 1930.

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Haemorrhage  
(Duration) 3 yrs. 3 mos. 3 ds.

Contributory  
Secondary

(Signed) J. F. Magraw M. D.  
May 7th 1930 (Address) Perryville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hopewell, County DATE OF BURIAL May 8, 1930

20 UNDERTAKER Rea Patterson ADDRESS Perryville Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 4 1896  
BUR

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

06611

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U. S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME JONES, Douglas H. C-1 261 827

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	---

## 6 DATE OF BIRTH

May 28, 1900.  
(Month) (Day) (Year)

## 7 AGE

30 yrs. 0 mos. 26 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed or (employer) ---9 BIRTHPLACE  
(State or country)Albany, Va.

## 10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1 Hospital Records,(Address) Perry Point, Md.15 Filed June 24 1930 Ed Charles W. Morrison Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 24, 1930.  
(Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended the deceased from February 26 1930 to June 24, 1930.that I last saw him alive on June 24, 1930.and that death occurred on the date stated above, at 5:38 A.M.

The CAUSE OF DEATH \* was as follows:

1. Tuberculosis, Pulmonary, chronic, advanced active. 2. Tuberculous enteritis, perforation of the bowel. 3. Peritonitis.  
Duration: #1. 3 yrs. #2. 9 mos. #3. 36 hrs.  
(Duration) yrs. mos. ds.
Contributory  
Secondary
 (Signed) F. E. Leslie (Duration) yrs. mos. ds.  
F. E. LESLIE, Med. Officer in Charge. M. D.  
June 24, 1930. (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death 3 yrs. 28 mos. 28 ds. In the State 3 yrs. 3 mos. 28 ds.
Where was disease contracted, if not at place of death? UnknownFormer or usual residence Bassett, Va.
 19 PLACE OF BURIAL OR REMOVAL  
Townes & Son, Undertakers  
Martinsville, Va.

## DATE OF BURIAL

June 26, 1930.

## 20 UNDERTAKER

Pennington & Son, Havre de Grace, Md.

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Cecil</u>		CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Etta Jones</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>Dec 29, 1929</u> (Month) (Day) (Year)			
7 AGE <u>1</u> yrs. <u>14</u> mos. <u>14</u> ds.		If LESS than 1 day ____ hrs. ____ min.?	
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>Ralston Jones</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
12 MAIDEN NAME OF MOTHER <u>Daisy Bellis</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Penn</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Robt Jones</u> (Address) <u>Elkton Md</u>			
15 Filed <u>Feb 13, 1930</u> <u>J. Howard Traylor</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Feb 12, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 8, 1930</u> to <u>Feb 12, 1930</u> , that I last saw her alive on <u>Feb 12, 1930</u> , and that death occurred on the date stated above, at <u>9 P.</u> m.			
The CAUSE OF DEATH * was as follows: <u>Broncho pneumonia</u> <u>Primary</u> (Duration) ____ yrs. ____ mos. <u>4</u> ds.			
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.			
(Signed) <u>M. T. Morrison</u> M. D. <u>Feb 13, 1930</u> (Address) <u>Elkton, Md</u>			
*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. <u>4</u> ds. In the State ____ yrs. ____ mos. ____ ds.			
Where was disease contracted, if not at place of death? Former or usual residence <u>Elkton Md</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Cemetery</u>		DATE OF BURIAL <u>Feb 13, 1930</u>	
20 UNDERTAKER <u>H. W. Pippin</u>		ADDRESS <u>Elkton Md</u>	

# CERTIFICATE OF DEATH

U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Farmer," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated; thus, *Farmer (retired)*. For persons who have no occupation whatever write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term, for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Cobalt pneumonia*; *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite, *Tuberculosis of lungs, meninges, peritoneum, etc.*, "Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Resolter wound, of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

2 FULL NAME Margaret Elizabeth Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Nov 1 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 5 mos. 28 ds. or min.?  
If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wallace Davis

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John McGool

(Address) Elkton Md.

15 Filed May 1st 1930 J. Frank Trayer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 29 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 21 1930 to Apr 29 1930

that I last saw her alive on Apr 29 1930

and that death occurred on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Herbert Bate M. D.  
4/30 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence Elkton R. J. D. Md

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery DATE OF BURIAL May 2, 1930

20 UNDERTAKER

N. W. Pippin ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The industrial worker on may form part of the second statement—never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masks (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 7 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil Co

13702

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95Village or City Rising Sun (No. \_\_\_\_\_)

St: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Philema Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Dec 26, 1863  
(Month) (Day) (Year)

7 AGE 66 yrs. 10 mos. 6 ds. or min. 2  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work house wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) arcadia Pa

10 NAME OF FATHER Ernest C Smith

11 BIRTHPLACE OF FATHER (State or country) Summerville Co Va

12 MAIDEN NAME OF MOTHER Mary E Toward

13 BIRTHPLACE OF MOTHER (State or Country) Arcadia Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theophilus Jones  
(Address) Rising Sun Md

15 Filed Nov 4 1930  
James W. Thompson Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 25, 1930 to Nov 2, 1930.

that I last saw him alive on Nov 2, 1930.and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH \* was as follows:

Paralytic Stroke

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) B. Shew M. D.Oct 13, 1930 (Address) Rising Sun

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bert Goar, Md. Nov 5, 1930

20 UNDERTAKER ADDRESS

J. E. Tyson Rising Sun Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

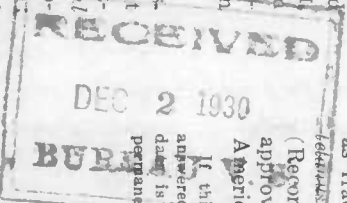
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group Typhoid fever (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E:haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicemia*, "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a preliminary check is made, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County CecilVillage or City Elk Neck Md (No. 182)

## 2 FULL NAME

William Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

## 6 DATE OF BIRTH

April 13, 1920  
(Month) (Day) (Year)

## 7 AGE

10 yrs. 2 mos. 21 ds. or LESS than 1 day hrs. min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)

School boy

## 9 BIRTHPLACE (State or country)

Penna

## 10 NAME OF FATHER

Ashton Lee Jones

## 11 BIRTHPLACE OF FATHER (State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Charlotte Dieffenbach

## 13 BIRTHPLACE OF MOTHER (State or Country)

Penna

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Herbert S. Beam  
319 Beverly Place, Wil. Del

## 15

7-4-30 192 Geo W. Quess  
Registrar

67905

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 4<sup>th</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920that I last saw him alive on 7/4, 1930and that death occurred on the date stated above, at 7:30 P M.  
The CAUSE OF DEATH \* was as follows:Accidental DrowningContributory  
Secondary

(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_ 1920 (Address) \_\_\_\_\_

\*State the Cause of Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal  
Accidental Drowning

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Chila Penna July 8, 1930

## 20 UNDERTAKER

## ADDRESS

Joseph P. Grant North East, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed for given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Beile

Village or City Rising Sun (No. \_\_\_\_\_)

2 FULL NAME Willis B. Jones

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 12, 1929  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. 4 mos. 19 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Willis Jones

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Ella McClaire

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Willis Jones

(Address) Rising Sun, md.

15 Filed 2-1-1930 Registrar James M. Montgomery

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 30, 1930 to Jan 31, 1930, that I last saw him alive on Jan 30, 1930,

and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Indigestion  
Secondary \_\_\_\_\_

(Signed) J. B. Oliver M. D.  
Jan 31, 1930 (Address) Beary Sew

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Int Good, md. DATE OF BURIAL Feb 2, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, md.

Permit issued 2-1-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1930

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WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Becil

Village or City

Rising Sun mds (No. \_\_\_\_\_)

2 FULL NAME

Charles Maurice Keicholtz

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

September 12, 1860  
(Month) (Day) (Year)

7 AGE

69 yrs. 11 mos. 25 ds. or min.?

If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

John Keicholtz

11 BIRTHPLACE OF FATHER (State or country)

Baltimore mds

12 MAIDEN NAME OF MOTHER

Sarah Jane Massey

13 BIRTHPLACE OF MOTHER (State or Country)

Balt. Co. mds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helia K Reeder

(Address)

Rising Sun

15

Filed

Sept 8 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 7, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
my 3.0 1930 to Sept 7, 1930

that I last saw him alive on Sept 7, 1930

and that death occurred on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH \* was as follows:

Arterio sclerosis.

Contributory  
Secondary(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) J. B. Shaw M. D.

Sept 8 1930 (Address) Rising Sun

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Brookview Md.

DATE OF BURIAL

Sept 10, 1930

20 UNDERTAKER

G. E. Tyson

ADDRESS

Rising Sun, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 9-8-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME Horner Kelley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Dec. 30, 1929  
(Month) (Day) (Year)

7 AGE 6 yrs. 18 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (state or country) Md.

10 NAME OF FATHER William Kelley

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Florence E. Flower

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Kelley

(Address) Perryville, Md.

15 Filed 7/20 1930 L. Sanders Registrar

07966 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 16th 1930 to July 18 1930  
that I last saw him alive on July 18 1930

and that death occurred on the date stated above, at 12-30 A.M.  
The CAUSE OF DEATH \* was as follows:

Cholera Infantum  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. F. Magraw M. D.  
July 19, 1930 (Address) Perryville, Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Perryville, Md. DATE OF BURIAL July 20, 1930

20 UNDERTAKER Lee Patterson ADDRESS Perryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			05433		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(90)		Registration Dist. No. <u>90</u>	
Village or City <u>Earleville</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Samuel Kelley</u>						
PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>May 1<sup>st</sup></u> , 19 <u>30</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , 19 <u>30</u> , that I last saw him <u>dead</u> on <u>3/1</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>7:30 P. m.</u>			
7 AGE <u>About 60</u> yrs. <u>0</u> mos. <u>0</u> ds. or min.?			The CAUSE OF DEATH * was as follows: <u>From information -</u> <u>Acute dilatation of</u> <u>the heart</u> Contributory <u>Secondary</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>J. C. Rowan Registrar</u> 192 (Address) <u>101 S. 1<sup>st</sup> St., Baltimore</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal			
9 BIRTHPLACE (State or country) <u>Delaware</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
PARENTS	10 NAME OF FATHER <u>Joshua Kelly</u>		19 PLACE OF BURIAL OR REMOVAL <u>Immaculate Cemetery</u> DATE OF BURIAL <u>May 1<sup>st</sup>, 1930</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>		20 UNDERTAKER <u>John H. Coffey</u> ADDRESS <u>Aciltron, Ind.</u>			
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Kemp</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Delaware</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Biddle</u> (Address) <u>Earleville</u>						
15 Filed <u>5/2</u> 19 <u>30</u> <u>J. C. Rowan</u> Registrar						

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**N. B.**--Every item of information should be carefully supplied. **ACE** should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

### 3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED.  
OR DIVORCEO  
(Write the word)

6 DATE OF BIRTH

7 AGE

## B OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer).

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER

11 BIRTHPLACE  
OF FATHER

12 MAIDEN NAME  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

13

Filed

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw h in alive on March 15, 1924

and that death occurred on the date stated above, at 9:44 m.

The CAUSE OF DEATH \* was as follows:

### Contributory Secondary

(Signed)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death.....yrs.....mos.....ds.

In the  
State.....yrn.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic nodular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia, Anaemia* (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<b>1 PLACE OF DEATH</b> County <u>Cecil</u> <u>Near North East</u> (No. <u>182</u> ) Village or City			<b>STATE OF MARYLAND</b> <b>CERTIFICATE OF DEATH</b> Registration Dist. No. <u>94</u>		
<b>2 FULL NAME</b> <u>Robert Kidd</u>			St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
<b>PERSONAL AND STATISTICAL PARTICULARS</b>					
<b>3 SEX</b> <u>Male</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> <u>Married</u> <small>(Write the word)</small>	<b>16 DATE OF DEATH</b> <u>July 9<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)		
<b>6 DATE OF BIRTH</b> <u>no record</u> , 18 <u>88</u> (Month) (Day) (Year)			<b>17 I HEREBY CERTIFY, That I attended the deceased from</b> <u>192</u> to <u>192</u> , that I last saw him alive on <u>7/9</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8 P.</u> m. <b>The CAUSE OF DEATH * was as follows:</b> <u>From information -</u> <u>Accidental Drowning</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) _____ M. D. 192 (Address) _____ *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Green (Brown)</u>		
<b>7 AGE</b> <u>42</u> yrs. _____ mos. _____ ds. or _____ min.? If LESS than 1 day, _____ hrs.			<b>18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)</b> At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
<b>8 OCCUPATION</b> (a) Trade, profession or particular kind of work. <u>Laborer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			<b>19 PLACE OF BURIAL OR REMOVAL</b> <u>Mt Moriah Cemetery Philadelphia</u>		
<b>9 BIRTHPLACE (State or country)</b> <u>Pa.</u>			<b>DATE OF BURIAL</b> <u>July 12, 1930</u>		
PARENTS	<b>10 NAME OF FATHER</b> <u>Edward Kidd</u>		<b>ADDRESS</b> <u>North East, Md.</u>		
	<b>11 BIRTHPLACE OF FATHER (State or country)</b> <u>N. J.</u>		<b>20 UNDERTAKER</b> <u>J. R. Grant</u>		
	<b>12 MARRIAGE NAME OF MOTHER</b> <u>Elizabeth Stogal</u>				
<b>13 BIRTHPLACE OF MOTHER (State or Country)</b> <u>Pa.</u>					
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Winfield Kidd</u> (Address) <u>North East Md</u>					
<b>15 Filed</b> <u>7-10-30</u> <u>Geo W. Owens</u> Registrar					

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

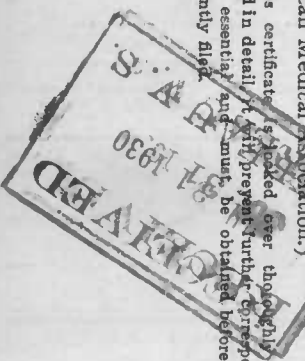
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No.     )

2 FULL NAME Mary M Kincaid

07908

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 20, 1850  
(Month) (Day) (Year)

7 AGE 80 yrs. 4 mos. 5 ds. or      min.?  
If LESS than 1 day      hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John H Young

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Ballenger

13 BIRTHPLACE OF MOTHER (State or Country) New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jam Kincaid  
(Address) Elkton 2nd

15 Filed July 27, 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1918 192 to July 25, 1930.

that I last saw him alive on July 24, 1930.

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:  
Arterio sclerosis

Contributory Secondary       
(Duration) 12 yrs.      mos.      ds.

(Signed) A. T. Thomson M. D.  
July 26, 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?     

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL July 27, 1930

20 UNDERTAKER H. W. Phipps ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County CECIL

14867 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City U.S. Veterans' Hospital, Perry Point, Maryland. St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME KING, Charles F.

C-470,460

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

Unknown, 1884  
(Month) (Day) (Year)

7 AGE

46 yrs. Unknown mos. --- da. or --- min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Winston Salem, N.C.

10 NAME OF FATHER

John King

11 BIRTHPLACE OF FATHER  
(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
(State or Country)

North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records - U.S. Veterans'

(Address) Hospital, Perry Point, Maryland.

15 Filed 1/1/30 192 Charles W. Duvessa  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December, 1930  
(Month) 8 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from January 18, 1928 to December 8, 1920.

that I last saw him alive on December 8, 1920.

and that death occurred on the date stated above, at 9:15 A.m.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia.

7 days.

(Duration) 7 yrs. --- mos. --- da.

Contributory  
Secondary

General Paralysis of the

Insane

(Duration) 2 yrs. 9 mos. 25 da.

(Signed) F.E. Leslie M. D.  
F.E. Leslie Medical Off. in Chg. U.S.V. Hosp.,  
December 8, 1930 (Address) Perry Point, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recant Residents)

At place of death 2 yrs. 10 mos. 20 ds. In the 2 yrs. 10 mos. 20 ds. State

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Greensboro, N.C.

19 PLACE OF BURIAL OR REMOVAL  
Swicegood Funeral Home,  
Danville, Virginia

DATE OF BURIAL

Dec. 11, 1930

20 UNDERTAKER

R. Madison Mitchell

ADDRESS

Havre de Grace,  
Maryland.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1921

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

02823

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City North East (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William M. King

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH  
Aug 24, 1915  
(Month) (Day) (Year)7 AGE  
14 yrs. 6 mos. 23 ds. or min.? If LESS than 1 day hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work School boy  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Va10 NAME OF FATHER Miles King11 BIRTHPLACE OF FATHER (State or country) Ark12 MAIDEN NAME OF MOTHER Lenora Cole13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miles King  
(Address) North East Md15 Filed 3-22-30 1922 E. W. Carson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 19, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Jan 11, 1930 to Mar 14, 1930 that I last saw him alive on Mar 14, 1930, and that death occurred on the date stated above, at 10 am. The CAUSE OF DEATH \* was as follows:EndocarditisContributory Rheumatism  
Secondary(Signed) A. J. Reed Endicott M. D.  
Mar 21, 1930 (Address) North East Md

\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M. E. Cemetery Mar 22, 1930

20 UNDERTAKER ADDRESS

Joseph R. Shaw North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930

BUR

WRITE IN PENCIL, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

05434

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

Village or City Elkton (No. \_\_\_\_\_)  
<sup>2</sup> FULL NAME Ada B. Kirk

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Nov 10 1886  
(Month) (Day) (Year)

7 AGE 43 yrs. 5 mos. 21 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Frank Beeson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Bristow

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Kirk  
(Address) Elkton, Md

15 Filed May 10 1930 Sharon Hays  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 28 1930 to May 6 1930.

that I last saw her alive on May 6 1930, and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary tuberculosis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Bates M. D.  
578 1930. (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery

May 10 1930

20 UNDERTAKER

ADDRESS

H. W. Pippin

Elkton, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.*. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County  Cecil

Village or City  Elkton  (No. \_\_\_\_\_)

2 FULL NAME  Leona F. Kline

01538

(10)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.  92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Female  4 COLOR OR RACE  white  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  Single

6 DATE OF BIRTH  Sept 20 , 19 19   
(Month) (Day) (Year)

7 AGE  10  yrs.  4  mos.  20  ds. or  LESS  than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  at school   
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)  Maryland

10 NAME OF FATHER  Allen Kline

11 BIRTHPLACE OF FATHER (State or country)  Maryland

12 MAIDEN NAME OF MOTHER  Lavinia Shaeffer

13 BIRTHPLACE OF MOTHER (State or Country)  Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  Allen Kline   
(Address)  Elkton, Md

15 Filed  Feb 10  19 30   Frank Trayer  Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  Feb 9 , 19 30   
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  Jan 31  19 30  to  Feb 9  19 30 , that I last saw her alive on  Feb 8 , 19 30 ,

and that death occurred on the date stated above, at  9 A.  m.  
The CAUSE OF DEATH \* was as follows:

Diphtheria

(Duration)  Probably  mos.  14  da.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)  H. A. Monahan  M. D.  
 Feb 10  19 30  (Address)  Elkton, Md

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Feb 10, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

MAR 6 1930  
BUREAU V. S.

BUREAU V. S.

unquaffed, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY, and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

unquaffed, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY, and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**N. B.--**Every item of information should be carefully supplied. **ACE** should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Eaton Union Hospital (No. \_\_\_\_\_)

2FULL NAME. Unamed Plukear

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
-----------------	--------------------------	---

6 DATE OF BIRTH Steel River, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than  
1 day \_\_\_\_\_ hrs.  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

3. OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) 2-8

10 NAME OF FATHER *Paul Kluck*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Poland*

12 MAIDEN NAME Mary Lukiegy  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER  
(State or Country) *no information*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Kluckieany

(Address) Elkton, Md Rd

15 Filed May 9 1972 F. Lewis Davis

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 1<sup>st</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
June 8<sup>th</sup> 1921 to June 8<sup>th</sup> 1921  
that I last saw him alive on June 8<sup>th</sup> 1921

and that death occurred on the date stated above, at 9. 20 m.  
The CAUSE OF DEATH \* was as follows:

(Duration) yrs mos ds.

Contributory  
Secondary

..... (Duration) ..... yrs ..... mos ..... ds.  
(Signed) Just P. [Signature] M. D.  
..... 192 ..... (Address) [Signature] .....

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... da.      In the State ..... yrs. .... mos. .... da.

Where was disease contracted,  
if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elston Catholic Cemetery	June 9, 1932

20 UNDERTAKER	ADDRESS
H. W. Higgins	Elkton Ind

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

see note from Dr Kane 4/26/31 about age and  
and D of mother

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 21 1930  
BUR



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County Cecilnear Leslie

Village or City

(No. \_\_\_\_\_)

14868 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marguerite Laird

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

June 22<sup>nd</sup>, 1929  
(Month) (Day) (Year)

7 AGE

1 yrs. 6 mos. 10 ds. or min.?  
If LESS than  
1 day \_\_\_\_ hrs.  
1 day \_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

MD

10 NAME OF FATHER

Stephen Laird

11 BIRTHPLACE OF FATHER

(State or country)

MD

12 MAIDEN NAME OF MOTHER

Marguerite Hammond

13 BIRTHPLACE OF MOTHER

(State or Country)

MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stephen Laird(Address) North East, Md.15 Filed 12-13-30 1930Geo. W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 12<sup>th</sup>, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192  
that I last saw her alive on 12/12, 1930and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH \* was as follows:

Cause undetermined  
from history, possibly  
Diphtheria or Streptococcus  
infection (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary(Signed) Geo. W. Owens Registrar  
12-13-1930 (Address) North East

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents\*)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

North East, M. E. Cemetery

DATE OF BURIAL

Dec 13, 1930

20 UNDERTAKER

Joseph R. Spear

ADDRESS

North East, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*—(the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU V. B.

There being no physician in  
attendance, this certificate was  
given to me by Howard H. Green  
Coroner -

Geo W. Ames

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County COUNTY Cecil

Village or City U.S. Veterans' Hospital, Perry Point, Maryland. St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME LANTON, Daniel C-1,084,278

Registration Dist. No. 96

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH 11, 23, 1893  
(Month) (Day) (Year)

7 AGE 36 yrs. 1 mos. 9 ds. or LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Turkey

10 NAME OF FATHER Frank Lanton

11 BIRTHPLACE OF FATHER (State or country) Turkey

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records, U.S. Veterans' Hospital  
(Address) Perry Point, Maryland.

15 Filed Jan 7 1930 Charles W. Morrison Registrar

0336 STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 16, 1930 to January 1, 1930,

that I last saw him alive on January 1, 1930,

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

Multiple Sclerosis

Approximately ten years

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) F. E. Leslie M. D.  
F. E. LESLIE, Medical Officer in Charge.  
Jan. 2, 1930 (Address) Perry Point, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 4 mos. 9 ds. In the State 4 yrs. 4 mos. 9 ds.

Where was disease contracted, it not at place of death? Unknown

Former or usual residence 1425 N. Peach Street, Phila., Pa.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Undertakers; Asher & Son, Inc.  
1309 N. Broad St., Phila., Pa. Jan. 4, 30

20 UNDERTAKER ADDRESS  
Pennington & Son, Havre de Grace, Maryland.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection, with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typoidal fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u> Cecil </u>		06613 (124)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u> Elkton </u> (No. <u> Union Hospital </u> )		St. <u> </u> Ward <u> </u>		Registration Dist. No. <u> 92 </u>	
2 FULL NAME <u> Harry M. Langelere </u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u> Male </u>	4 COLOR OR RACE <u> white </u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u> Married </u> (Write the word)			
6 DATE OF BIRTH <u> May 16 </u> , 18 <u> 52 </u> (Month) (Day) (Year)		16 DATE OF DEATH <u> June 7 </u> , 19 <u> 30 </u> (Month) (Day) (Year)			
7 AGE <u> 78 </u> yrs. <u> 0 </u> mos. <u> 21 </u> ds. or <u> </u> min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u> June 8 </u> , 19 <u> 30 </u> , to <u> June 7 </u> , 19 <u> 30 </u> , that I last saw him alive on <u> June 5 </u> , 19 <u> 30 </u> , and that death occurred on the date stated above, at <u> 9:25 </u> p.m. The CAUSE OF DEATH * was as follows: <u> Colon infection of Gallbladder with gangrene </u> (Duration) <u> 5 </u> yrs. <u> </u> mos. <u> </u> ds.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u> Brick mason </u> (b) General nature of industry, business, or establishment in which employed or (employer) <u> </u>		Contributory Secondary <u> R. H. M. Smith </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. (Signed) <u> June 9 </u> , 19 <u> 30 </u> (Address) <u> Elkton Md </u> M.D.			
9 BIRTHPLACE (State or country) <u> Maryland </u>		*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
10 NAME OF FATHER <u> Nicholas Langelere </u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds.			
11 BIRTHPLACE OF FATHER (State or country) <u> Pennsylvania </u>		Where was disease contracted, if not at place of death? <u> </u>			
12 MAIDEN NAME OF MOTHER <u> Martha Mitchell </u>		Former or usual residence <u> </u>			
13 BIRTHPLACE OF MOTHER (State or country) <u> Pennsylvania </u>		19 PLACE OF BURIAL OR REMOVAL <u> Elkton Cemetery </u>		DATE OF BURIAL <u> June 10, 1930 </u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u> Mrs. Alice Langelere </u> (Address) <u> Elkton Md </u>		20 UNDERTAKER <u> H. W. Pippin </u>		ADDRESS <u> Elkton Md </u>	
15 Filed <u> June 7 </u> , 19 <u> 30 </u> <u> Frank Hager </u> Registrar					

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rendrer wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NEG 192 NMF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Eekton (No. RD)

2 FULL NAME Lillie Emma Layton

02824

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 19, 1926  
(Month) (Day) (Year)

7 AGE 3 yrs. 9 mos. 11 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edwin M. Layton

11 BIRTHPLACE OF FATHER (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Agnes Krejci

13 BIRTHPLACE OF MOTHER (State or Country) Czech (Slovakia)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin M. Layton  
(Address) Eekton Rd RD

15 Filed 192 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 24, 1930 to Mar 30, 1930, that I last saw her alive on Mar 29, 1930, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH \* was as follows:

Scarlet Fever  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Signed) Herbert Bates M. D.  
3/30 1930 (Address) Eekton Rd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Eekton Cemetery DATE OF BURIAL April 31, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Eekton Rd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plowman, Pugsleian, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up, on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1910

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Cecil</u>		CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u> (No. <u>49</u> )		St. _____	Ward _____
2 FULL NAME <u>Mary Elizabeth Leamon</u>		Registration Dist. No. <u>95</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>April 21</u> , 1880 (Month) (Day) (Year)			
7 AGE <u>49</u> yrs. <u>9</u> mos. <u>5</u> ds. or LESS than 1 day ____ hrs. or ____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>C. C. Kyle</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
12 MAIDEN NAME OF MOTHER <u>Jane Lynch</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank Leamon</u> (Address) <u>Cecil, Md. R.D. 5</u>			
15 Filed <u>Jan 29-31</u> 1930 <u>James H. Montgomery</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan - 26</u> , 1930 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec - 10</u> , 192 <u>9</u> , to <u>Jan 16</u> , 1930, that I last saw her alive on <u>Jan 16</u> , 1930, and that death occurred on the date stated above, at <u>11 40</u> a.m.			
The CAUSE OF DEATH * was as follows: <u>Sarcoma of left eye -</u> <u>General Metastasis</u> (Duration) <u>1</u> yrs. <u>-</u> mos. <u>-</u> ds.			
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>C. J. Brinson</u> M. D. <u>1/27</u> 1930 (Address) <u>Port Deposit, Md.</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Rising Sun Cemetery</u>		DATE OF BURIAL <u>Jan 29, 1930</u>	
20 UNDERTAKER <u>A. J. Abernethy</u>		ADDRESS <u>Cecil, Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A life data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 4 1930  
BUREAU

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Point (No. 161-0)

2 FULL NAME Dr. Forest C. Leach, Jr.

6338 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Jan. 16, 1930  
(Month) (Day) (Year)

7 AGE 7 yrs. 0 mos. 0 ds. or 25 min.?  
If LESS than 1 day 4 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Dr. Forest Leach

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Ester Charchee

13 BIRTHPLACE OF MOTHER (State or Country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Forest C. Leach

(Address) Centre Square

15 Filed 1-17 1930 L. Barden

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 16, 1930 to Jan 16, 1930

that I last saw him alive on Jan 16, 1930

and that death occurred on the date stated above, at 1:45 m.  
The CAUSE OF DEATH \* was as follows:

Premature  
7 months  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) J. H. Benson M. D.  
17 1930 (Address) Port Republic

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL (DATE OF BURIAL)

20 UNDERTAKER ADDRESS Lee A. Patterson Berryville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 8 1920  
BUREAU V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

12336

(44)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U. S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME LEHR, John C-Spanish American War Veteran.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
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6 DATE OF BIRTH

May 20, 1 869.

(Month) (Day) (Year)

7 AGE

61 yrs. 4 mos. 17 ds. or \_\_\_\_\_ min.?

If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

Farm9 BIRTHPLACE  
(State or country)Germany

10 NAME OF FATHER

Michael Lehr11 BIRTHPLACE OF FATHER  
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Mary Lameska13 BIRTHPLACE OF MOTHER  
(State or Country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Perry Point, Md.15 Filed Oct. 7 1930 Charles W. Sullivan

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 6, 1930.

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from September 6, 1930. to October 6, 1930.that I last saw him alive on October 6, 1930and that death occurred on the date stated above, at 12:26 P.m.

The CAUSE OF DEATH \* was as follows:

Cancer of the stomach. 2. Aneurysm of the thoracic aorta.(Duration) 1 & 2 - Unknown yrs. mos. ds.Contributory  
SecondaryPsychosis with CerebralArteriosclerosis, pronounced. Duration: Unknown yrs. mos. ds.(Signed) F.E. Leslie M. D.  
F.E. LESLIE, Med. Officer in Charge.  
October 7, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 30 ds.In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 30 ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 1412 E. Gough St., Balto., Md.

19 PLACE OF BURIAL OR REMOVAL

National Cemetery, Loudon Park, Balto., Md.

DATE OF BURIAL

Oct. 7, 1930

20 UNDERTAKER

R. Madison Mitchell, Havre de Grace, Md.

ADDRESS

R. Madison Mitchell

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

NOV 5 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

County

Cecil

12337

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton

(No. ....)

St. ....

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Leibig

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

October 1

(Month)

(Day)

1930 (Year)

7 AGE

Premature

If LESS than

1 day hrs.

yrs. 3

mos.

ds.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Elkton, Md.

10 NAME OF FATHER

William Leibig

11 BIRTHPLACE OF FATHER

(State or country)

Elkton, Md.

12 MAIDEN NAME OF MOTHER

Oline Rhodes

13 BIRTHPLACE OF MOTHER

(State or country)

Elkton, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Oct 7 1930

J. Frank Rizer

Registrar

16 DATE OF DEATH

October 1

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

October 1st 1930 to October 1st 1930

that I last saw him alive on October 1st 1930

and that death occurred on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH \* was as follows:

Premature birth

(Duration)

yrs. 3

mos. .... ds.

Contributory Secondary

(Duration)

yrs. .... mos. .... ds.

(Signed)

J. Frank Rizer

M. D.

192 (Address)

Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. .... mos. .... ds.

In the State

yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

10-1, 1930

20 UNDER SIGNATURE

Parents

ADDRESS

Signed of by J. Frank Rizer

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Raveler wound of head—homicide; Poisoned by carbohc acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City near Sector (No. \_\_\_\_\_)

2 FULL NAME Miscarriage Leidbich

05435

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ? 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 2, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?  
yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Md

10 NAME OF FATHER C. Raymond Leidbich

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Seelayer

13 BIRTHPLACE OF MOTHER (State or Country) Mich

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C.R. Leidbich

(Address) Sector Md Rt 2

15 Filed May 3 1930 J. Frank Taylor Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 192\_\_,

and that death occurred on the date stated above, at 119 m.  
The CAUSE OF DEATH \* was as follows:

2 mos miscarriage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Baker M. D.  
5/2 1930 (Address) Sector Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Premises 5/2, 1930

20 UNDERTAKER ADDRESS

Parents

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

02825

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City U.S. Veterans' Hospital, Perry Point, Md. St.        Ward       

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME LEONARD, Ralph L. C-1 083 544

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 2, 1891.  
(Month) (Day) (Year)

7 AGE 38 yrs. 8 mos. 30 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry, business, or establishment in which employed or (employer) ---

9 BIRTHPLACE (State or country) Uniontown, Pa.

10 NAME OF FATHER William J. Leonard

11 BIRTHPLACE OF FATHER (State or country) Uniontown, Pa.

12 MAIDEN NAME OF MOTHER Anna Williams

13 BIRTHPLACE OF MOTHER (State or Country) Bradys Bend, Armstrong Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records  
(Address) Perry Point, Md.

15 Filed 3/1 1923 L. L. Sander Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from January 10, 1929 to March 1, 1930.

that I last saw him alive on March 1, 1930.

and that death occurred on the date stated above, at 6:10 A.M.  
The CAUSE OF DEATH \* was as follows:

1. Endocarditis, chronic with Mitral Stenosis and Tricuspid Stenosis.

2. Pleurisy with effusion, probably Tubercular. (Duration) 1. Unknown mos. \_\_\_\_ ds.

Contributory 1. Dementia Praecox, Hebephrenic Type, pronounced. 2. Nephritis, chronic. (Duration) #1 5 yrs. mos. \_\_\_\_ ds.

(Signed) F. E. LESLIE, M.D. Officer in Charge.  
March 1, 1930. (Address) Perry Point, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 12 ds. In the State 1 yrs. 1 mos. 12 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 2617 Broadway, Dormont, Pittsburgh,

19 PLACE OF BURIAL OR REMOVAL Pa. DATE OF BURIAL March 3, 1930.  
Slater Undertaking Establishment

Mt. Washington, Pittsburgh,  
20 UNDERTAKER Pa. ADDRESS Pennington & Son, Havre de Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Village or City

(No.)

St. Ward

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

11-4 1930

L. J. Sanders

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov-2-1930  
Oct-30-1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct-30-1930 to Nov-1-1930

that I last saw her alive on Nov-1-1930

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH \* was as follows:

Addisonian  
Pernicious

Anaemia

(Duration) yrs. 2 mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. J. Benson M. D.  
11/3 1930 (Address) Pat. Department

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			14869		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>92</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
Village or City <u>near Elkton</u> (No. _____)			St. _____ Ward _____			
2 FULL NAME <u>John Lewis</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Dec. 27<sup>th</sup></u> , 19 <u>30</u>			
6 DATE OF BIRTH <u>Feb. 24<sup>th</sup></u> , 18 <u>64</u>			(Month) _____ (Day) _____ (Year) _____			
7 AGE <u>66</u> yrs. <u>10</u> mos. <u>3</u> ds. or _____ min.?			17 I HEREBY CERTIFY, That I attended the deceased from _____ 19 <u>2</u> to _____ 19 <u>2</u> , that I last saw him <u>dead</u> on <u>12/27</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>6:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Fractured Skull</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds. <u>(Auto accident)</u>			
9 BIRTHPLACE (State or country) <u>England</u>			(Duration) _____ yrs. _____ mos. _____ ds. <u>Coroner</u>			
10 NAME OF FATHER <u>John Lewis</u>			(Signed) <u>Howard W. Green</u> M.D. <u>12/27</u> , 19 <u>30</u> (Address) <u>Elkton, Md</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>England</u>			State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
12 MAIDEN NAME OF MOTHER <u>Unknown</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
13 BIRTHPLACE OF MOTHER (State or Country) <u>England</u>			Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>Mrs. Lizzie Lewis</u> (Informant) (Address) <u>Elkton, Md. No 3</u>			19 PLACE OF BURIAL OR REMOVAL <u>Elkton cemetery</u>		DATE OF BURIAL <u>Dec 30</u> , 19 <u>30</u>	
15 Filed <u>Dec. 30</u> 19 <u>30</u> <u>J. Paul Trapp</u> Registrar			20 UNDERTAKER <u>H. H. Phipps</u>		ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 7 1931  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Bevil

Village or City Rowlandville (No. \_\_\_\_\_)

2 FULL NAME Baby Lewis

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 2, 1930  
(Month) (Day) (Year)

7 AGE Still Born If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Leslie Lewis

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Styer

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie Lewis  
(Address) Rowlandville md.

15 6-3-30 30  
Permit issued 6-3-1930  
Registrar

If more blanks are needed address State Registrar, 16 W. Seneca St., Belts., Requesting V. S. No. 1.

06614

②

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 2, 1930 to June 30, 1930.

that I last saw him alive on \_\_\_\_\_, 1930.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still Birth

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. E. Tyson M. D.

June 3, 1930 (Address) Rowlandville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Harmony Chapel

DATE OF BURIAL

June 3, 1930

20 UNDERTAKER

A. E. Tyson

ADDRESS

Rowlandville md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Apr 14 1920 C. S. Grant  
Registrar

04162

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920 to 1920

that I last saw her alive on 19 Feb 1920

and that death occurred on the date stated above, at 240 a.m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed) M. H. McKnight M. D.

April 2nd 1920 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery

Apr 4 1920

20 UNDERTAKER

ADDRESS

H. W. Pippin

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 3 1930  
BUREAU

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## 1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

8 DATE OF BIRTH

7 AGE

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, of establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER

11 BIRTHPLACE

OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

1920

Registrar

12338

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 1 P. m.  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary

(Signed)

1920 (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childish or miscearriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by acetic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City North East (No. \_\_\_\_\_)

2 FULL NAME Barry Collings Logan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Feb 23, 1930  
(Month) (Day) (Year)

7 AGE 1 yrs. 8 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Howard Logan

11 BIRTHPLACE OF FATHER md Penna  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Collings

13 BIRTHPLACE OF MOTHER md  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Logan  
(Address) North East md

15 Filed 11-9-30 1930 Geo W. Quince  
Registrar

13704  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 9H

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 6, 1930 to Nov 7, 1930, that I last saw him alive on Nov 7, 1930

and that death occurred on the date stated above, at 8:10 a.m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage caused by the convulsions.

Contributory Secondary Convulsions  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) H. A. Ambrose M. D.  
Nov 7, 1930 Address North East

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East, M.E. DATE OF BURIAL Nov 9, 1930

20 UNDERTAKER Joseph A. Hunt ADDRESS North East

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

02826

(188-C)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96Village or City Port Deposit (No. 1)Richards Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William Lorenz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH April 30, 1847  
(Month) (Day) (Year)

7 AGE 82 yrs. 11 mos. 21 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER John Lorenz

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Anna FrankR.O. 1 (Address) Bird-In-Hand, Pa.

15 Filed 3/31, 1930  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 30, 1930 to March 31, 1930  
that I last saw him alive on March 31, 1930

and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH \* was as follows:

Auto-accident was met with railroad train  
Fractured Skull - Lacerations  
Rt lung (auto accident)  
Fractured ribs. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 1/2 ds.

Contributory Acute Edema 1/2 ds.  
Secondary Fracture of ribs 1/4 ds.  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. H. Richards M. D.  
3/31, 1930 (Address) Port Deposit

\*State the Disease causing Death, or in deaths from Violent causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  
Dr. W. H. Green (Coroner)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL Woodward Hill DATE OF BURIAL Apr 3, 1930

20 UNDERTAKER J. Fred Fisher & Son ADDRESS Lancaster Pa.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930  
BUREAU OF VITALS



MARGIN RESERVED FOR BINDING

WRITE NAME, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County  Cecil

Village or City  Elkton R.D.  (No.  129 )

2 FULL NAME  Isaac F. Lort

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No.  92

St.   Ward   (if death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Male  4 COLOR OR RACE  white  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  Married

6 DATE OF BIRTH  Nov 25 , 18 55   
(Month) (Day) (Year)

7 AGE  74  yrs.  3  mos.  3  ds. If LESS than 1 day   hrs. or   min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  Farmer   
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)  Maryland

10 NAME OF FATHER  Joseph Lort

11 BIRTHPLACE OF FATHER (State or country)  Maryland

12 MAIDEN NAME OF MOTHER  Jane Curry

13 BIRTHPLACE OF MOTHER (State or Country)  Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  Mrs Kate Lort   
(Address)  Elkton Md Rd

15 Filed  Mar 3  19 30   J. Frank Taylor  Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  2   25 , 19 30   
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  2-15  19 30  to  2-20  19 30   
that I last saw him alive on  2-20  19 30

and that death occurred on the date stated above, at  2  a.m.

The CAUSE OF DEATH \* was as follows:  
 Chronic Interstitial Nephritis & Myocarditis

Contributory Secondary (Duration)   yrs.   mos.   ds.

(Signed)  J. Frank Taylor  M. D.  
 1930  (Address)  Elkton Md

\*State the Cause Causing Death or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death   yrs.   mos.   ds. In the State   yrs.   mos.   ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  North East Cemetery (Md)  DATE OF BURIAL  Mar 3 , 19 30

20 UNDERTAKER  H. W. Pippin  ADDRESS  Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU V. I.

WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City

2 FULL NAME John J. Lotman

STATE OF MARYLAND  
CERTIFICATE OF DEATH

10297

(90)

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH June 17, 1884  
(Month) (Day) (Year)

7 AGE 46 yrs. 2 mos. 13 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Fireman Boat  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Lotman

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara Robinson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lotman

(Address) Elkton Md

15 Filed 9/4 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,

that I last saw him dead on 9/1, 1930

and that death occurred on the date stated above, at 11 P m.

The CAUSE OF DEATH \* was as follows:

from information -  
Acute Dilatation of  
the Heart  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_, 192 (Address) \_\_\_\_\_  
\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Beechel Cemetery DATE OF BURIAL Sept 4, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 3 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

01540

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

Village or City Conowingo (No.       )

St.        Ward       

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elizabeth Griest Love

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct. 18, 1888  
(Month) (Day) (Year)

7 AGE 41 yrs. 4 mos. 4 ds. or        LESS than 1 day        hrs. or        min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Isaac Griest

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Caldwell

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. B. Love  
(Address) Conowingo, Md.

15 Filed 2-23 1930 Registrar Louise M. M. M. M.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 14, 1930 to Feb. 22, 1930  
that I last saw him alive on Feb. 22, 1930,

and that death occurred on the date stated above, at 10 p. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Bright's Disease with Bronchial Pneumonia

(Duration)        yrs.        mos. 9 ds.  
Contributory Natural  
Secondary       

(Signed) F. B. Croogans M. D.  
Feb. 23, 1930 (Address) Darlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Darlington Cem. DATE OF BURIAL Feb. 25, 1930

20 UNDERTAKER St. S. Bailey ADDRESS Darlington

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 2-23-1930

Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, keloid*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH.  
County Cecil

Village or City Conowingo No. \_\_\_\_\_

2 FULL NAME James Medford Love

04163

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 3, 1887  
(Month) (Day) (Year)

7 AGE 42 yrs. 9 mos. 11 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Telegraphy  
(b) General nature of industry, business, or establishment in which employed or (employer) P.R.R.

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Charles B. Love

11 BIRTHPLACE OF FATHER (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary A. McCoy

13 BIRTHPLACE OF MOTHER (State or Country) Penna.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Helen E. Love

(Address) Conowingo Md.

15 Filed Apr 15 - 1930  
Miss Montington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15, 1930 to April 14, 1930.

that I last saw him alive on April 14, 1930.

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH \* was as follows:  
Pulmonary Tuberculosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Natural

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) H. P. Snodgrass M. D.

4-15-1930 (Address) Washington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fairfield, Pa. April 17, 1930

20 UNDERTAKER ADDRESS

J. E. Tyson Rising Sun, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

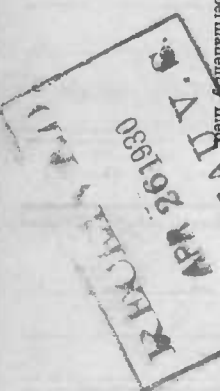
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is checked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County: Cecil

Village or City North East (No. \_\_\_\_\_)

2 FULL NAME Reba J. Lowe

12339

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 25, 1889  
(Month) (Day) (Year)

7 AGE 41 yrs. — mos. 3 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work milliner  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Emory Lowe

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Scotten

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Emory Lowe

(Address) Wilmington Del

15 Filed 10-31-30 192 Geo W. Success  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 3, 1923 to Oct 28, 19230  
that I last saw her alive on Oct 28, 19230

and that death occurred on the date stated above, at 5:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Asthenia

Contributory Secondary \_\_\_\_\_

(Duration) 7 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) C. B. Starnes M. D.  
Oct 29, 1930 (Address) North East md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M. E. Cemetery Nov 1, 1930

20 UNDERTAKER ADDRESS

Joseph A Shaw North East

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME Still Birth

06615 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 10, 1930  
(Month) (Day) (Year)

7 AGE Still Birth If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Still Birth

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Wm J. Lyons

11 BIRTHPLACE OF FATHER (State or country) Del.

12 MAIDEN NAME OF MOTHER Pearl N. Campbell

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearl N. Lyons

(Address) Perryville

15 Filed 6/10 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 10, 1930 to June 10, 1930, that I last saw him Still Born June 10, 1930

and that death occurred on the date stated above, at 8:20 a.m.  
The CAUSE OF DEATH \* was as follows:

Premature Birth

Contributory (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Secondary Placental Aemia

(Signed) J. F. Magraw M. D.  
June 10, 1930 (Address) Perryville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL On Premises DATE OF BURIAL June 10, 1930

20 UNDERTAKER Wm J. Lyons (Father) ADDRESS Perryville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; . . . . . shopteumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia;" (trereely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930

BUREAU

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Providence (No. \_\_\_\_\_)

2 FULL NAME Muscainige

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 93

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan 28, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Md.

10 NAME OF FATHER Earl T. Mogaw

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Sprack

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl T. Mogaw  
(Address) Elkton Md Rt 2

15 Filed 192 \_\_\_\_\_ Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_ to \_\_\_\_\_, 192\_\_\_\_,

that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH \* was as follows:

Muscainige  
2 1/2 months gestation  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary Fall on ice

(Signed) Herbert Bates M. D.  
1/28 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Premises DATE OF BURIAL 1/28, 1930

20 UNDERTAKER Parents ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1910

BUREAU

WRITE A COPY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton

2 FULL NAME Ralph J. Maguire

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, Married  
(Write the word)  
6 DATE OF BIRTH Jan. 23<sup>rd</sup> 1888  
(Month) (Day) (Year)  
7 AGE 42 yrs. 4 mos. 4 ds. If LESS than 1 day \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Accountant  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Bernard Maguire  
11 BIRTHPLACE OF FATHER (State or country) Can.  
12 MOTHER'S NAME OF MOTHER Evelyn Daley  
13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. Marga. Maguire  
(Informant)

(Address) 1608 W. 14<sup>th</sup> St. Wilmington Del.

15 Filed May 28 19230 Frank Trayer  
Registrar

05438

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27<sup>th</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 27 - 1930 to May 27 - 1930, that I last saw him alive on 5/27/30, and that death occurred on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH \* was as follows:  
Fractured Skull  
(Automobile accident)

Contributory  
Secondary

(Signed) James P. Murrell M. D.  
19230 (Address) Elkton Del.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wilmington Del. DATE OF BURIAL May 30, 1930

20 UNDERTAKER W. P. Phipps ADDRESS Elkton Del.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			06617 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Rising Sun</u> (No. _____) St. _____ Ward _____			Registration Dist. No. <u>95</u>		
2 FULL NAME <u>Anthony Manquette</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u>	16 DATE OF DEATH <u>June 26</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>about 55</u> yrs. _____ mos. _____ ds. or _____ min.?			17 I HEREBY CERTIFY, That I attended the deceased from 19 <u>2</u> to <u>6/26</u> , 19 <u>30</u> that I last saw him <u>alive</u> on _____, 19 <u>30</u>		
7 AGE <u>about 55</u> yrs. _____ mos. _____ ds. or _____ min.?			and that death occurred on the date stated above, at <u>11 A.</u> m. The CAUSE OF DEATH * was as follows: <u>From information -</u> <u>Acute dilatation of</u> <u>the heart</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) _____			(Signed) _____ M. D.		
10 NAME OF FATHER _____			192 _____ (Address) _____		
11 BIRTHPLACE OF FATHER (State or country) _____			*State the Disease Causing Death or, in cases from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
12 MAIDEN NAME OF MOTHER _____			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
13 BIRTHPLACE OF MOTHER (State or Country) _____			Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>1</u> (Address) _____					
15 Filed <u>6-27-1930</u> <u>John H. Manquette</u> Registrar <u>Permit Court 6-27-1930</u>			19 PLACE OF BURIAL OR REMOVAL <u>Brookview Cemetery</u> 20 UNDERTAKER <u>J. E. Ryan</u>		
			DATE OF BURIAL <u>June 28, 1930</u> ADDRESS <u>Rising Sun, Md.</u>		
If more blanks are needed, address State Registrar, 18 W. Saratoga St., Balto., Requesting V. S. No. 1.					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., (*Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 2 1930

BUREAU V. S.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County CecilVillage or City U.S. Veterans' Hospital, Perry Point, Md.STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME MANNING, Leon J. C-1 309 744

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Unknown

 6 DATE OF BIRTH March 1 1899  
 (Month) (Day) (Year)

 7 AGE 30 yrs. under mos. under ds. or min.?  
 IF LESS than 1 day \_\_\_\_ hrs.

 8 OCCUPATION  
 (a) Trade, profession or particular kind of work Unknown  
 (b) General nature of industry business, or establishment in which employed or (employer) ---
9 BIRTHPLACE (State or country) Florida10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Hospital Records  
 (Address) Perry Point, Md.
15 Filed 2/20 30 Challard Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH February 19, 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from February 14 1930 to February 19 1930, that I last saw him alive on February 19, 1930,

 and that death occurred on the date stated above, at 6:15 P.m.  
 The CAUSE OF DEATH \* was as follows:  
Pneumonia, type undetermined
Dementia Praecox 6 mos. 6 ds.  
Contributory Catatonic Stupor  
Secondary

 (Duration) Unknown ds.  
 (Signed) F. E. Leslie M. D.  
F. E. LESLIE, Medical Officer in Charge.  
Feb. 20 1930 (Address) Perry Point, Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death \_\_\_\_ yrs. 6 ds. In the State \_\_\_\_ yrs. 6 ds.
Where was disease contracted, if not at place of death? UnknownFormer or usual residence Tallahassee, Fla.
 19 PLACE OF BURIAL OR REMOVAL Tallahassee, Fla. DATE OF BURIAL Feb. 23, 1930.  
 Undertaker: J. A. Culley,  
 20 UNDERTAKER Pennington & Son, Havre de Grace, Md.
ADDRESS Pennington & Son, Havre de Grace, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL puerilis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by rolling train—accident, Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH  
County Besse

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Miss Fannie

02828

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
6 DATE OF BIRTH June 27, 1866 (Month) (Day) (Year)  
7 AGE 63 yrs. 8 mos. 17 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry, business, or establishment in which employed or (employer) Drug Store

9 BIRTHPLACE (State or country) Maryland  
10 NAME OF FATHER Robert Marshbank

11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Eliza Lynch  
13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Margaret Wells  
(Address) Elkton Md

15 Filed March 17, 1920 Frank Beyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 14, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 5, 1920 to March 14, 1920, that I last saw her alive on March 14, 1920,

and that death occurred on the date stated above, at 1155a m. The CAUSE OF DEATH \* was as follows:

Influenza

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. 16  
Contributory Acute myocarditis  
Secondary

(Signed) T. H. Mc Knight M. D.  
3-14-20 (Address) Elkton Md

\*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery DATE OF BURIAL March 17, 1920

20 UNDERTAKER H. W. Pizzie ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Pastrycook, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired)*, or *Dr.*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1906  
BUREAU V. S.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton Union Hospital (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Walter Charles Martin

02829 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 6, 1904  
(Month) (Day) (Year)

7 AGE 25 yrs. 9 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Employee  
(b) General nature of industry, business, or establishment in which employed or (employer) AT & T. Co

9 BIRTHPLACE (State or country) Penn

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Mary E. Nicely

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Martin  
(Address) Ligonier Pa

15 Filed Mar 25 1930 John Trager Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 19, 1930 to March 24, 1930, that I last saw him alive on March 24, 1930, and that death occurred on the date stated above, at 11:20 p.m. The CAUSE OF DEATH \* was as follows:

Peritonitis following ruptured appendix.  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory acute appendicitis  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) John J. Martin M. D.  
\_\_\_\_\_. 192\_\_\_\_ (Address) Elkton

\*State the Cause Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Latrobe Pa DATE OF BURIAL Mar 27, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time, and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

Village or City

near Leslie (No. ....)

## 2 FULL NAME

Wm. J. Marvel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

54

St.: Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

July 16, 1871  
(Month) (Day) (Year)

7 AGE

59 yrs. 11 mos. 12 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Railroad Conductor

9 BIRTHPLACE

(State or country)

Del

10 NAME OF FATHER

Alford Marvel

11 BIRTHPLACE OF FATHER

(State or country)

Del

12 MAIDEN NAME OF MOTHER

Amanda Sullivan

13 BIRTHPLACE OF MOTHER

(State or Country)

Del

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A Howard Evans

(Address)

38 E. Fort Ave Balto. Md

15

Filed 7-4-30 192 Geo W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 4<sup>th</sup>, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 7/4, 1930

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH \* was as follows:

Struck by railway  
train (Duration) yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Howard W. Green M.D.

7/4 1930 (Address) Cleeblin Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery, Balto. Md

July 7, 1930

20 UNDERTAKER

ADDRESS

Joseph A. Shaw

North East Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

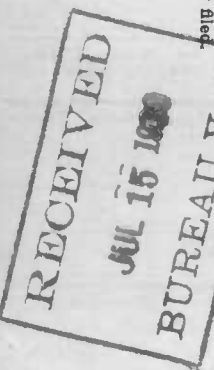
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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07911

STATE OF MARYLAND  
CERTIFICATE OF DEATH

PLACE OF DEATH

County

Cecil

WITHIN CORPORATE LIMITS OF

Registration Dist. No.

92

Village or City

Elkton

(No.)

Union Hospital

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Frank

Matthews

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

September 20, 1919

(Month)

(Day)

(Year)

7 AGE

50 yrs.

7 mos.

21 ds.

If LESS than

1 day

hrs.

or

min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Frank Matthews

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

No Information

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Viola Matthews

(Address)

Elkton Md.

15

Filed

July 14, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

11

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

July 30, 1930 to July 11, 1930

that I last saw him alive on July 11, 1930

and that death occurred on the date stated above, at 2:10 P. M.

The CAUSE OF DEATH \* was as follows:

Streptococcal Infection  
of Right Foot

(Duration)

yrs.

mos.

11 ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

V. H. Mc Knight

M. D.

July 11, 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

3 ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Elkton, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Colored Cemetery

July 14, 1930

20 UNDERTAKER

ADDRESS

N. W. Pippin

Elkton Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scars, keloids*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 7 1900

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

Village or City Near Earleville (No. 129)

2 FULL NAME William C. Matthews

04164 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH 1 18 1849  
(Month) (Day) (Year)

7 AGE 81 yrs. 3 mos. 10 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER Wrigate Matthews

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah E. Callaway

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Blanche C. Matthews

(Address) Earleville, Md.

15 Filed 4/30 1930 J. C. Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 27, 1930 to Apr. 28, 1930, that I last saw him alive on Apr. 28, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH \* was as follows:

Chronic Indurated Nephritis

Contributory Secondary Uremia

(Duration) Indefinite yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Geo. P. Jones M. D. Apr. 29, 1930 (Address) Calum, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Earleville Cemetery DATE OF BURIAL May 1, 1930

20 UNDERTAKER John H. Coffey ADDRESS Earleville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or marriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WHEN FILING, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Beall Co

Village or City Rowlandville Md (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Helen Alberta McClaine

6339

(1592)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE MARRIED, WIDDED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 13 1930  
(Month) (Day) (Year)

7 AGE 13 yrs. 13 mos. 13 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Rowlandville Beall Co Md

10 NAME OF FATHER Stephen McClaine

11 BIRTHPLACE OF FATHER (State or country) Beach Bottom Pa

12 MAIDEN NAME OF MOTHER Helen Alexander Bodde

13 BIRTHPLACE OF MOTHER (State or country) Wilmington Del

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Helen A McClaine  
(Address) Rowlandville Md

15 1-27-31  
Filed 1-27-31  
George M. Worthington REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 26 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1930 to Jan 26 1930  
that I last saw him alive on Jan 25 1930  
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH was as follows:

Congenital Heart  
from birth  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 ds.

Contributory Malformation of Heart  
Secondary  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 ds.

(Signed) George M. Worthington  
Jan 26 1930 (Address) Liberty Grove

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, \_\_\_\_\_  
If not at place of death? ✓  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mt Zora DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Earle Dupree ADDRESS Prigging

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence.—All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 4 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Eltown (No. \_\_\_\_\_)

2 FULL NAME George Lee McCabe

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 4, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?  
yrs. \_\_\_\_\_ mos. 20 ds. or \_\_\_\_\_

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Paul B. McCabe

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Alice R Logan

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elenore Logan  
(Address) Eltown, Ind.

15 Filed Sept 25, 1930 J. Frank Trager  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 4, 1930 to Sept 24, 1930  
that I last saw him alive on Sept 24, 1930

and that death occurred on the date stated above, at 7 P m.  
The CAUSE OF DEATH \* was as follows:

Spinal Diphtheria  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) M. T. Jones M. D.  
Sept 25, 1930 (Address) Northampton, Ill.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cecil New Cemetery, Del. DATE OF BURIAL Sept 27, 1930

20 UNDERTAKER A. J. Ahrens ADDRESS Eltown, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 6 1930

BOR

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1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. \_\_\_\_\_)

2 FULL NAME Jay Wallace McCoy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 17, 1929  
(Month) (Day) (Year)

7 AGE 1 yrs. 30 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jefferson D. McCoy Jr

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Ellen Shelton

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jefferson D. McCoy Jr  
(Address) Chesapeake City, Md RD

15 Filed 8/19 1930 B. Howard Brown  
Registrar

09126

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(113)

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 10, 1930 to Aug 16, 1930

that I last saw him alive on Aug 16, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows: Gastritis

Contributory Secondary (Duration) 0 yrs. 1 mos. 0 ds.

(Signed) Dr. J. Morrison M. D.  
Aug 18, 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Aug 19, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City.

2 FULL NAME Jefferson Davis McCoy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Jan 17, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 6 mos. 24 ds. or min. ? If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer (Retired)  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Nathan McCoy

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Wabinsky

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Jefferson D. McCoy  
(Address) Chesapeake City, Md.

15 Filed Aug 14, 1930 B. Howard Brown  
Registrar

09127 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8-11-1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 8/11/30 192 to 8-11-30 192  
that I last saw him alive on 8-11-30 192

and that death occurred on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH \* was as follows: Acute cardiac dilatation

Contributory (Duration) yrs. mos. ds. Chronic Myocarditis  
Secondary

(Signed) John E. Van Dusen M. D.  
8-11-30 192 (Address) Chesapeake City, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery Md. DATE OF BURIAL Aug 14, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to show (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Henry Mitchell McCullough

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 24 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 4 mos. 26 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Lawyer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James T. McCullough

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Mitchell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Carrie B. McCullough

(Address) Elkton Md

15 Filed Feb 22 1930 J. Banks Taylor Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 20 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1928 to Feb 20 1930

that I last saw him alive on Feb 20 1930

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma of bladder & rectum: primary in prostate gland. Ca. & B.

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory  
Secondary

(Duration) 3 yrs. 1 mos. 6 ds.

(Signed) Herbert B. B. M. D.  
2/20 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 6 mos. 6 ds. In the State 3 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Feb 22 1930

20 UNDERTAKER W. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

05436

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 98

Village or City Coloma Md. (No. 74a)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Emma Mc Culbough

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH July 25<sup>th</sup>, 1860  
(Month) (Day) (Year)

7 AGE 69 yrs. 10 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work retired  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Lewis E. Martindell

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elamora Sidwell

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nettie Cleverlin

(Address) Coloma Md.

15 Filed May 9, 1930 Registrar James M. Worthington

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 2, 1930 to May 5, 1930, that I last saw her alive on May 7, 1930.

and that death occurred on the date stated above, at 1235 P.M.

The CAUSE OF DEATH \* was as follows:

Apoplexy, Cerebral  
hemorrhage of brain

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Ernest Fursted M. D.  
May 8, 1930 (Address) Liberty Grove Rd.

\* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Ind. DATE OF BURIAL May 10, 1930

West Nottingham

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Md.

Permit issued 5-9-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

RECEIVED

JUN 3 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

23

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			01542		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Beech</u>			(31)		Registration Dist. No. <u>95</u>	
Village or City <u>Rising Sun</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Delena Lee McDougal</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>				
6 DATE OF BIRTH <u>12</u> <u>15</u> <u>1853</u> (Month) (Day) (Year)						
7 AGE <u>76</u> yrs. <u>1</u> mos. <u>25</u> ds. or _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
10 NAME OF FATHER <u>G. H. Jeffries</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Penna</u>						
12 MAIDEN NAME OF MOTHER <u>Phoebe Ann Smith</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>May de. McDougal</u> (Address) <u>Rising Sun, Md</u>						
15 <u>Feb 12 1930</u> <u>Louis M. Washington</u> Registrar <u>Delena Lee McDougal</u> 2-12-1930						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>2</u> <u>10</u> <u>1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>2-8</u> <u>1930</u> to <u>2-10</u> <u>1930</u> , that I last saw him alive on <u>2-9</u> <u>1930</u> , and that death occurred on the date stated above, at <u>8 AM</u> pm.						
The CAUSE OF DEATH * was as follows: <u>Tuberculosis</u> (Duration) _____ yrs. _____ mos. _____ ds.						
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.						
(Signed) <u>Reed Doctor</u> M. D. <u>2-12-1930</u> (Address) <u>Rising Sun, Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Brookview Cem</u>					DATE OF BURIAL <u>2-13</u> <u>1930</u>	
20 UNDERTAKER <u>Mrs. Jennie Taylor</u>					ADDRESS <u>Rising Sun, Md</u>	
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, *Anaemia* (merely symptomatic), *Atrophy*, "Collapse," *Coma*, "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 5 1930  
BUREAU V

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Cecil*

05437

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *95*

Village or City

*M Rising Sun*(No. *1*)

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Irvin Mc Dowell*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Male White**married*

6 DATE OF BIRTH

*March 16**1868*

(Month)

(Day)

(Year)

7 AGE

*64*

yrs.

*2*

mos.

*8*

ds.

If LESS than

1 day.....hrs.

or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Penn.*

10 NAME OF

FATHER

*William McDowell*

11 BIRTHPLACE

OF FATHER

(State or country)

*Penn.*

12 MAIDEN NAME

OF MOTHER

*Mary Ely*

13 BIRTHPLACE

OF MOTHER

(State or Country)

*Penn.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Bertha McDowell*

(Address)

*Rising Sun Md*

15

Filed

*May 27 1930**J. H. Hittington*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*5**25**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*5/25**1930*to *6/25**1930*

that I last saw him live on

*5/25**1930*and that death occurred on the date stated above, at *12456*

The CAUSE OF DEATH \* was as follows:

*Coronary  
Artery  
Necrosis*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*W. D. Jones*

(Address)

*626 Rising Sun Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Graves Cem Briel**May 28 1930*

20 UNDERTAKER

ADDRESS

*Clyde E. Mason**Offord Pa.*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

*Irvin McDowell 5-27-30*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solomon, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonocum, etc., Corchoma, Sorcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Unemia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED

JUN 3 1924

BUR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

07963

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City new Elkton (No. .... St.: .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Clarence E. McConigal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE married  
MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH June 1 - 1904  
(Month) (Day) (Year)

7 AGE 26 yrs. 1 mos. 16 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Businessman  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas McConigal

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER May Walker

13 BIRTHPLACE OF MOTHER (State or Country) St. Louis, Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas McConigal  
(Address) St. Louis, Mo.

15 Filed 7/19 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920,  
that I last saw him alive on 7/17, 1930

and that death occurred on the date stated above, at 6.30 P. m.  
The CAUSE OF DEATH \* was as follows:

Accidental Electrocution

Contributory Secondary (Duration) yrs. mos. ds.  
(Signed) Howard W. Green M. D.  
7/18 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Angel Hill DATE OF BURIAL July 20 1930

20 UNDER TAKER Cumington & Son ADDRESS 24 d.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1530  
BUREAU V. 5

MARGIN RESERVED FOR BINDING

WRITE ALWAY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

02827

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. Union Hospital St.          Ward         ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Infant Metcown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 22, 1930  
(Month) (Day) (Year)

7 AGE          If LESS than 1 day 14 hrs.          yrs.          mos.          ds. or          min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work           
(b) General nature of industry business, or establishment in which employed or (employer)         

9 BIRTHPLACE (State or country) Elkton Md.

10 NAME OF FATHER Geo. B. Metcown

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Sara Brown

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. B. Metcown

(Address) Elkton Md R.D.

15 Filed March 23, 1930 Frank Trager Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 22, 1930 to March 23, 1930.

that I last saw him alive on March 22, 1930,

and that death occurred on the date stated above, at 6a. m.

The CAUSE OF DEATH \* was as follows: congenital debility

Contributory Premature delivery  
Secondary         

(Signed) Herbert Bales M. D.  
3/23/30 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death          yrs.          mos.          ds. In the State          yrs.          mos.          ds.

Where was disease contracted, if not at place of death?         

Former or usual residence         

19 PLACE OF BURIAL OR REMOVAL Presbyterian cemetery DATE OF BURIAL Mar 23, 1930

20 UNDERTAKER H. W. Papp ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 5 1930

BUREAU



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Cecil

WITHIN CORPORATE LIMITS BY

(129)

14870

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

93

Village or City

Elkton

(No.)

West Street

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs. William J. McNeal

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Apr 7, 1881

(Month)

(Day)

(Year)

7 AGE

80 yrs. 8 mos. 13 ds. or min.?

IF LESS than  
1 day hrs.  
min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Cecil Co Md

10 NAME OF FATHER

Daniel Fayman

11 BIRTHPLACE OF FATHER

(State or country)

Cecil Co Md

12 MAIDEN NAME OF MOTHER

Reed

13 BIRTHPLACE OF MOTHER

(State or Country)

Helen

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt McNeal

(Address)

Noble Pa

15

Filed

Dec 22 1930 C. S. Grant

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 30, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 1, 1930 to Dec 30, 1930

that I last saw her alive on Dec 30, 1930

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis -

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

H. C. Gendrich M. D.

1930 (Address) West Ant.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cherry Hill Cem

DATE OF BURIAL

Dec 22, 1930

20 UNDERTAKER

C. S. Grant &amp; Son

ADDRESS

Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECORDED  
JAN 2 1931  
BUREAU OF VITALS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Formerly engaged 6 yrs*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Chup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

CC. 3 100  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME George McVey

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Feb. 21, 1853.  
(Month) (Day) (Year)

7 AGE 77 yrs. 5 mos. 22 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Farm Laborer

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Nathan McVey

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Elizabeth Waibel

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine McVey

(Address) Perryville, Md.

15 Filed 8/14 1930 L. F. Sanders  
Registrar

## 09128 STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 13, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1st, 1930, to August 13, 1930, that I last saw him alive on August 12, 1930.

and that death occurred on the date stated above, at 6 P. m.  
The CAUSE OF DEATH \* was as follows:

General Atheromata  
(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Angina Pectoris  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. J. Magraw M. D.  
Aug 14 1930 (Address) Perryville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Harmony Chapel DATE OF BURIAL Aug 16 1930

20 UNDERTAKER Cecil Patterson ADDRESS Perryville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum, etc., Corcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			06616 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Perryville P.O.</u> (No. <u>90</u> )			Registration Dist. No. <u>96</u>		
2 FULL NAME <u>Joshua Andrew Mc Vey</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>	16 DATE OF DEATH <u>June 10</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>June 28</u> , 18 <u>53</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>March 1</u> , 19 <u>30</u> to <u>June 10</u> , 19 <u>30</u> , that I last saw him alive on <u>June 10</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic Valvular Heart Disease</u> (Duration) <u>5</u> yrs. mos. ds.		
7 AGE <u>74</u> yrs. <u>11</u> mos. <u>18</u> ds. or min.?			Contributory Secondary		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Acid Burner</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Fertilizer Mill</u>			(Duration) yrs. mos. ds.		
9 BIRTHPLACE (State or country) <u>Md.</u>			(Signed) <u>J. F. Magraw</u> M. D. <u>June 11</u> , 19 <u>30</u> (Address) <u>Perryville Md.</u>		
PARENTS	10 NAME OF FATHER <u>Nathan Mc Vey</u>		*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Wivill</u>		At place of death yrs. mos. ds. In the State yrs. mos. ds.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Penna.</u>		Where was disease contracted, if not at place of death?			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George Mc Vey</u> (Address) <u>Perryville, Md. P.O.</u>					
15 Filed <u>6/12</u> 19 <u>30</u> <u>L Sanders</u> Registrar		19 PLACE OF BURIAL OR REMOVAL <u>St. Pleasant Cem.</u>		DATE OF BURIAL <u>June 13</u> 19 <u>30</u>	
		20 UNDERTAKER <u>See A. Patterson</u>		ADDRESS <u>Perryville Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chronic pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Not named Meaders

Registration Dist. No. 92

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 15, 1930 (Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. If LESS than 1 day 0 hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Meaders

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Edith M. Webb

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Jan 22 1922 J. Frank Zaver Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 18, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 18 1920 to Jan 18 1920, that I last saw h alive on Jan 18 1920,

and that death occurred on the date stated above, at am. The CAUSE OF DEATH \* was as follows:

Still born  
6 months pregnancy  
(Duration) 0 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) H. T. Morrison M. D.  
Jan 19 1920 (Address) H. T. Morrison

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Body disposed of by , 19

20 UNDERTAKER ADDRESS

Hospital authorities

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 6 1930  
BUREAU



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## 1 PLACE OF DEATH

County Cecil

0342

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City Near Bay View (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah A Mearns

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

Dec141857

(Month)

(Day)

(Year)

7 AGE

72030ds.If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Penna

10 NAME OF

FATHER

Parber Harding

11 BIRTHPLACE

OF FATHER

(State or country)

not known

12 MAIDEN NAME

OF MOTHER

not known

13 BIRTHPLACE

OF MOTHER

(State or Country)

not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman Hall

(Address)

North East R. D.

15

Filed 1-16-30 192Geo W. Queen

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 13, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1-12 1930 to 1-13 1930that I last saw him alive on 1-13 1930and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH \* was as follows:

Cardiac  
asthma

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Reed Johnson M.D.1-14 1930 (Address) Residence

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calvert Friends Cemetery Jan 16, 1930

20 UNDERTAKER

ADDRESS

Joseph R. Hunt North East

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB  
BUREAU

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD 2)

2 FULL NAME George T Meekins

02830  
(74-2)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 11, 1859  
(Month) (Day) (Year)

7 AGE 71 yrs. 2 mos. 10 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
a) Trade, profession or particular kind of work Day Laborer  
b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Nathaniel Meekins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Bolton

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Laura Davis  
(Address) Elkton 2nd RD 2

15 Filed Mar 15 1930 Frank J. Beyer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 1, 1930 to Mar 21, 1930.

that I last saw him alive on Mar 20, 1930.

and that death occurred on the date stated above, at 11:58 p.m.

The CAUSE OF DEATH was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 7 ds.  
Contributory Arterio Sclerosis  
Secondary

(Signed) Herbert Bales M. D.  
3/21/30 (Address) Elkton Md

State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Still Pond Md DATE OF BURIAL March 25, 1930

20 UNDERTAKER H W Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 5 1922

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. HYSL- CIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Wheatland

2 FULL NAME William - 2 Mrs. Stillborn

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 911

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Apr 7, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. IF LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Stillborn  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil Co Md

10 NAME OF FATHER Jesse William

11 BIRTHPLACE OF FATHER (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Amelie Clarke

13 BIRTHPLACE OF MOTHER (State or country) Cecil Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. A. Cumberland

(Address) Wheatland

15 Filed 4-8-30 192 Geo W. Owens  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,

that I last saw him alive on 192,

and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH \* was as follows:

Stillborn - about 2 mos  
(Duration) yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) H. A. Cumberland M. D. Apr 7, 1930 (Address) Wheatland, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Retired (retired 6 yrs). For persons who have no occupation whatever, write None.**

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septiciæmia," "PERIPERAL puerperitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Fredericktown (No. 10300)

2 FULL NAME Eva Michael Kie witz

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept. 9<sup>th</sup>, 1919  
(Month) (Day) (Year)

7 AGE 11 yrs. 7 mos. 7 ds. or min.? (If LESS than 1 day hrs. min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Scholar  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER John Michael

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Eva Patro

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva Michael

(Address) 427 Chester St. Balto. Md.

15 Filed Sept 18 19230 J. W. Cragg Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18<sup>th</sup>, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 12<sup>th</sup> 9/18, 19230  
that I last saw her alive on 9/18, 19230

and that death occurred on the date stated above, at 5:10 P. M.  
The CAUSE OF DEATH \* was as follows:

From information  
Accidental Drowning  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) \_\_\_\_\_ M. D.

19230 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. Md. Sept 20, 19230

20 UNDERTAKER

ADDRESS 1730

J. W. Cragg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. Balto. Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations for statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is copied over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
U. S. V. S.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton Union Hospital (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

01544 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

2 FULL NAME Frank Clinton Miller Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 21, 1926  
(Month) (Day) (Year)

7 AGE 3 yrs. 8 mos. 23 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Frank Clinton Miller Sr.

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Simpser

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millie Simpser  
(Address) Elkton Md

15 Filed Feb 24 1927 J. Frank Miller Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 14<sup>th</sup>, 1927  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 11<sup>th</sup> 1927 to Feb. 14<sup>th</sup> 1927  
that I last saw him alive on Feb. 14<sup>th</sup> 1927

and that death occurred on the date stated above, at 11:20 m.  
The CAUSE OF DEATH \* was as follows:

as a result of the  
glaucoma  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Joel P. Phipps M. D.  
192\_\_\_\_ (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Elkton Md

19 PLACE OF BURIAL OR REMOVAL Elkton Colored Cemetery DATE OF BURIAL Feb 25, 1927

20 UNDERTAKER H. W. Phipps ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
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1 PLACE OF DEATH County <u>Cecil</u>		0343		STATE OF MARYLAND CERTIFICATE OF DEATH 93	
Village or City <u>Providence</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Joseph W. Miller</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>No Information</u> (Month) (Day) (Year)					
7 AGE <u>About 49 yrs</u> If LESS than 1 day ____ hrs. 1 day ____ hrs. 2 yrs. ____ mos. ____ ds. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Barber</u> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Delaware</u>					
PARENTS	10 NAME OF FATHER <u>John Miller</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>				
	12 MAIDEN NAME OF MOTHER <u>Belle Wade</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Joseph Miller</u> (Address) <u>Eeklog Md R.O.S.</u>					
15 Filed <u>Jan 27 1930</u> <u>J. Francis Trayer</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan. 24, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>1924</u> to <u>1930</u> , that I last saw him alive on <u>1/24, 1930</u> , and that death occurred on the date stated above, at <u>4 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Cerebral Apoplexism</u> <u>and Emphysema</u> (Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u>J. Francis Trayer M.D.</u> _____, 192____ (Address) _____					
*State the disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Green, (Crone)</u>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Sharp Cemetery</u>					DATE OF BURIAL <u>Jan 28, 1930</u>
20 UNDERTAKER <u>G. J. Chemmichy</u>					ADDRESS <u>Eeklog, Md.</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Fireman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Hæmiparesis," "Old Age," "Shock," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 8 1930  
BUR

If more blanks are needed, address State Registrar

Permit issued Apr 11-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 2 1930  
BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>			06618 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Cecil Mills</u> (No. <u>149</u> )			Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Marie Lucy Miller</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Sept 6</u> , 1891 (Month) (Day) (Year)				
7 AGE <u>38</u> yrs. <u>9</u> mos. <u>16</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Minnesota</u>				
10 NAME OF FATHER <u>Frederick Miller</u>				
11 BIRTHPLACE OF FATHER <u>Germany</u>				
12 MAIDEN NAME OF MOTHER <u>Wilhelmina Johnson</u>				
13 BIRTHPLACE OF MOTHER <u>Germany</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Herbert Miller</u> (Address) <u>Cecil Mills, Md</u>				
15 Filed <u>June 25 1930</u> J. Frank Page Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>June 22<sup>nd</sup></u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>192</u> m.				
The CAUSE OF DEATH * was as follows: <u>Post delivery</u> <u>Coronary embolism</u>				
(Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.				
Contributory Secondary <u>Pregnancy</u>				
(Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.				
(Signed) <u>Howard Johnson</u> M. D. <u>June 25 1930</u> (Address) <u>Newark Del.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. In the State <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Cherry Hill Cemetery</u>				DATE OF BURIAL <u>June 27, 1930</u>
20 UNDERTAKER <u>A. S. Clements</u>				ADDRESS <u>Cecil Mills, Md</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUL 2 1936  
BUR

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

06016 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton No. 4

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Minker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

6 DATE OF BIRTH may 29, 1930  
(Month) (Day) (Year)

7 AGE 9 If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?  
yrs. 9 mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Elkton

10 NAME OF FATHER Harry A. Minker

11 BIRTHPLACE OF FATHER (State or country) Elkton, Md.

12 MAIDEN NAME OF MOTHER Marguerite Craig

13 BIRTHPLACE OF MOTHER (State or Country) Earlville, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Marguerite Minker

(Address) Elkton

15 Filed June 20 1930 J. Frank Zayer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 29, 1930  
(Month) May (Day) 29 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from May 29, 1930 to May 29, 1930  
that I last saw him alive on May 29, 1930

and that death occurred on the date stated above, at 7:00 a.m.  
The CAUSE OF DEATH \* was as follows:

Premature birth

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Paul G. Gummel M. D.  
192 \_\_\_\_\_ (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Parents

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *Tertiary syphilis*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUL 8 1930  
BUREAU

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Probably L. A. Mitchell

07912  
(187-a)  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Unknown  
(Write the word)

6 DATE OF BIRTH Unknown  
(Month) (Day) (Year)

7 AGE about 38 yrs. — mos. — ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Unknown

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1

(Address) \_\_\_\_\_

15 Filed July 25 1930 J. Frank Trayer  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 7/25, 1930  
that I last saw him dead alive on \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

From information —  
Struck by railway train  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_ 192. (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal  
Green, Coroner

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Alms House Md. July 25, 1930

20 UNDERTAKER ADDRESS

H. W. Pippin Elkton Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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1 PLACE OF DEATH

County

Cecil

07913

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

72

Village or City

Elkton

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Wm Washington Montgomery

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Oct 8

1855

(Month)

(Day)

(Year)

7 AGE

74

yrs.

9

mos.

21

ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed or (employer)

fisherman

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Wm Montgomery

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

no information

13 BIRTHPLACE OF MOTHER

(State or Country)

no information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Harry Moore

(Address)

Elkton, Md

15

Filed

July 30 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 29 - 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23 - 1930 to July 29 - 1930

that I last saw him alive on July 28 - 1930

and that death occurred on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Embolism

(Duration)

yrs.

mos.

ds.

Contributory Secondary

Chronic myocarditis

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. Phipps

M. D.

192

(Address)

Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Elkton Catholic Cemetery

DATE OF BURIAL

July 31, 1930

20 UNDERTAKER

H. W. Phipps

ADDRESS

Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

12340

(151)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake City (No. R.D.) Bohemia Bridge St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Samuel Henry Moore

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Sept. 12, 1852  
(Month) (Day) (Year)

7 AGE 78 yrs. 1 mos. 4 ds. or min. If LESS than 1 day hrs.

### OCCUPATION

(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Kent Co. Maryland

10 NAME OF FATHER Thomas Moore  
11 BIRTHPLACE OF FATHER Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER no information

13 BIRTHPLACE OF MOTHER no information  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Samuel H Moore  
(Address) Chesapeake City, Md

15 Filed 10/17 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 13, 1930 to Oct 16, 1930, that I last saw him alive on October 9, 1930, and that death occurred on the date stated above, at 3 A. m.

The CAUSE OF DEATH \* was as follows:

Generalized Septicemia

(Duration) yrs. mos. ds.  
Contributory Painful rh. ag.  
Secondary (Duration) yrs. mos. ds.

(Signed) Catherine Goodson M. D.  
Oct 16, 1930 (Address) Cecilton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Galena Cemetery, Md. DATE OF BURIAL Oct 18, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Nervant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 3 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Pecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Warner C. Moore

02831

100-0

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 22, 1929  
(Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. 2 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Cecil Moore

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Bertha Brown

13 BIRTHPLACE OF MOTHER (State or Country) Del

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cecil Moore  
(Address) Elkton Rd. md

15 Filed March 25 1930 J. Frank Hayes  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 15, 1930 to March 24, 1930, that I last saw him alive on Mar 23, 1930,

and that death occurred on the date stated above, at 3 a. m. The CAUSE OF DEATH \* was as follows:

Broncho Pneumonia

Contributory Acute Bronchitis  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Bales M. D.  
3/26/30 1930 (Address) Elkton md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cherry Hill m. e. Cemetery DATE OF BURIAL Mar, 19 30

20 UNDERTAKER Joseph A. Shaw ADDRESS North East md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City Port Deposit (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2 FULL NAME

Harriette M. MoranSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married6 DATE OF BIRTH August 25, 1875  
(Month) (Day) (Year)7 AGE 54 yrs. 7 mos. 6 ds. or min. 2  
If LESS than 1 day \_\_\_\_ hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

England  
10 NAME OF FATHER John Bauman11 BIRTHPLACE OF FATHER (State or country) Ireland12 MAIDEN NAME OF MOTHER Leone Robinson13 BIRTHPLACE OF MOTHER (State or Country) England

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Murray(Address) Port Deposit, Md.15 Filed 10/3 1930 L. F. Sanders  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 2, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept. 25, 1930 to Oct. 2, 1930,  
that I last saw him alive on Oct. 1, 1930,  
and that death occurred on the date stated above, at 49 m.

The CAUSE OF DEATH \* was as follows:

Gangren both feet  
(Duration) yrs. mos. 10 ds.Contributory  
Secondary Arterio Sclerosis(Signed) Oct 2, 1930 W. G. Fair M. D.  
(Address) Charlottesville, Va.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

mt. Zion Cemetery Oct. 4, 1930.  
20 UNDERTAKER Penningtonson Delaware, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

04167

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City

Chesapeake City

St:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Henry Clay Morgan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Aug 21, 1853

(Month)

(Day)

(Year)

7 AGE

76 yrs. 6 mos. 5 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF

FATHER

James W. Morgan

11 BIRTHPLACE

OF FATHER

Maryland

12 MAIDEN NAME

OF MOTHER

Rebecca Ann Hays

13 BIRTHPLACE

OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hattie Ellison

(Address)

Chesapeake City Md

15

Filed

April 27, 1920

B. Howard Beaton

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 16, 1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from April 15, 1920 to April 16, 1920.

that I last saw him alive on April 25, 1920.

and that death occurred on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral embolism

(Duration) yrs. mos. ds.

Contributory  
Secondary

Chronic emphysema

(Duration) yrs. mos. ds.

(Signed)

Jacob J. Morgan M. D.

1920

(Address)

Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St Stephens Cemetery Cecil Co Md

DATE OF BURIAL

Apr 28, 1920

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

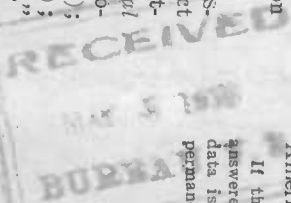
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service, for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Fredericktown Md

2 FULL NAME Robert C. Morgan

05439

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE; MARRIED, WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH

2 (Month) 3 (Day) 1848 (Year)

7 AGE

82 yrs. 3 mos. 13 ds. or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Ch. Horse

9 BIRTHPLACE (State or country)

Cecil Co. Ind.

10 NAME OF FATHER

John W. Morgan

11 BIRTHPLACE OF FATHER (State or country)

Cecil Co. Ind.

12 MAIDEN NAME OF MOTHER

Mary Gale

13 BIRTHPLACE OF MOTHER (State or Country)

Baltimore C. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mary Woodall  
Georgetown Md

15

Filed

5/16 19230

J. H. Rowan

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Mar. 19 1930 to May 16, 1930

that I last saw him alive on May 12, 1930

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH \* was as follows:

Organic Valvular Heart.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Geo. R. Jones M. D.

May 16, 1930 (Address) Galeton Md.

\* State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Galeton Cemetery

May 19<sup>th</sup>, 1930

20 UNDERTAKER

ADDRESS

John W. Caffrey

Cecilton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930  
BUREAU V. S.

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1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. 89)

2 FULL NAME Eliza J Morris

01545 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 71

St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 15, 1855  
(Month) (Day) (Year)

7 AGE 74 yrs. 7 mos. 13 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Joseph Costello

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER May J. Pierce

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. Booker  
(Address) Chesapeake City, Md.

15 Filed 2/22 1930 B. Hammond Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-18-30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2-18-30 1930 to 2-18-30, 1930,

that I last saw him alive on 2-18-30, 1930,

and that death occurred on the date stated above, at 10:50 P. m.  
The CAUSE OF DEATH \* was as follows:

Arterio-sclerosis

Contributory Secondary Angina pectoris  
(Duration) yrs. mos. da.

(Signed) Wm. E. Van Norden M. D.  
2/20/30 1930 (Address) Chesapeake City, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Feb 22, 1930

20 UNDERTAKER H. W. Pippine ADDRESS Elkton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 8 1930

BUREAU V. S.

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1 PLACE OF DEATH County <u> Cecil </u>		02832 (91-C)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u> Port Deposit </u>		St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u> Charles A. Morrison </u>		Registration Dist. No. <u> 96 </u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u> male </u>	4 COLOR OR RACE <u> white </u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u> married </u>			
6 DATE OF BIRTH <u> May 31 - 1873 </u> (Month) (Day) (Year)		7 AGE <u> 56 yrs. 9 mos. - </u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u> Superintendent </u> (b) General nature of industry, business, or establishment in which employed or (employer) <u> State Roads </u>					
9 BIRTHPLACE (State or country) <u> Maryland </u>					
10 NAME OF FATHER <u> George W. Morrison </u>					
11 BIRTHPLACE OF FATHER (State or country) <u> Pennsylvania </u>					
12 MAIDEN NAME OF MOTHER <u> Harriet Murphy </u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u> Maryland </u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u> Mrs. Morrison </u> (Address) <u> Port Deposit, Md. </u>					
15 Filed <u> 3/3 </u> 19 <u> 30 </u>		L. H. Sanders Registrar			
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u> March 1, 1930 </u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u> Feb 10 </u> 192 <u> 30 </u> to <u> March 1 </u> 192 <u> 30 </u> that I last saw him alive on <u> March 1 </u> 192 <u> 30 </u> and that death occurred on the date stated above, at <u> 5 30 </u> a.m. The CAUSE OF DEATH * was as follows: <u> acute myocarditis </u> <u> dilatation of aorta </u> (Duration) yrs. <u> 4 </u> mos. <u> - </u> ds. Contributory <u> acute rupture of aorta </u> Secondary (Duration) yrs. <u> - </u> mos. <u> - </u> ds. (Signed) <u> J. H. Richard </u> M. D. <u> 3/1 </u> 192 <u> 30 </u> (Address) <u> Port Deposit </u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. <u> - </u> mos. <u> - </u> ds. In the State yrs. <u> - </u> mos. <u> - </u> ds. Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u> Hopewell Cemetery Md. </u>				DATE OF BURIAL <u> Feb. 4, 1930 </u>	
20 UNDERTAKER <u> Pennington &amp; Co. H. de Guise, Md. </u>				ADDRESS	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1920  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH		STATE OF MARYLAND	
County <u>Cecil</u>		CERTIFICATE OF DEATH <sup>92</sup>	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		Registration Dist. No. <u>94</u>	
2 FULL NAME <u>Caroline Martin Morton</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>June 4</u> 18 <u>86</u> (Month) (Day) (Year)			
7 AGE <u>43</u> yrs. <u>10</u> mos. <u>26</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Robert G. Bryan</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Virginia Bruce</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Morton</u> (Address) <u>North East Md</u>			
15 Filed <u>5-3-30</u> 192 <u>0</u> <u>E. W. Grooms</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 1</u> 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Apr 28</u> 19 <u>30</u> to <u>May 1</u> 19 <u>30</u> that I last saw her alive on <u>Apr 30</u> 19 <u>30</u> and that death occurred on the date stated above, at <u>6:10 A.</u> m.			
The CAUSE OF DEATH * was as follows: <u>General Peritonitis</u> (Duration) yrs. mos. <u>3</u> ds.			
Contributory Secondary (Signed) <u>A. J. Lewis</u> M. D. <u>May 2</u> 19 <u>30</u> (Address) <u>North East Md</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>North East Cemetery</u>		DATE OF BURIAL <u>May 4</u> 19 <u>30</u>	
20 UNDERTAKER <u>G. J. Abernethy</u>		ADDRESS <u>Elkton Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worker on 'may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Cerebromus, Sorcomu, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

JUN 3 1930  
BUREAU V. B.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			12342		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(78)		Registration Dist. No. <u>92</u>	
Village or City <u>near Elkton</u> (No. <u>Rd 2</u> )			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Catherine Mullen</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>April 22<sup>nd</sup></u> , 190 <u>6</u> (Month) (Day) (Year)						
7 AGE <u>24</u> yrs. <u>5</u> mos. <u>29</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>MD</u>						
10 NAME OF FATHER <u>Andrew Stahl</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>						
12 MAIDEN NAME OF MOTHER <u>Unknown</u>						
13 BIRTHPLACE OF MOTHER _____						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Francis Mullen</u> (Address) <u>Elkton, MD Rd 2</u>						
15 FILED <u>Oct 23 1920</u> <u>Francis Mullen</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Oct 21<sup>st</sup></u> , 192 <u>0</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>1920</u> to <u>1920</u> , that I last saw <u>or died</u> <u>10/21</u> , 192 <u>0</u> , and that death occurred on the date stated above, at <u>11 A</u> m. The CAUSE OF DEATH * was as follows: <u>Suffocation</u> <u>Due to Epileptic</u> <u>Convulsions</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) <u>John Green M.D.</u> (Address) <u>Elkton</u>						
*State the Disease causing Death, or, in Deaths from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>John Green (Coroner)</u>						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Cemetery</u>					DATE OF BURIAL <u>Oct 23</u> , 192 <u>0</u>	
20 UNDERTAKER <u>H. W. Pippin</u>					ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

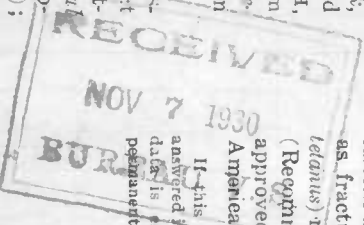
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Cerebroma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





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<sup>1</sup> PLACE OF DEATH  
County Becil

Village or City Blythedale (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME Minerva E. Marlier

12343 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH May 16, 1946  
(Month) (Day) (Year)

7 AGE 84 yrs. 5 mos. 11 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER James H. McCullough

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Edna McCullough

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah E. McCray

(Address) Blythedale, Md.

15 Filed Oct 30 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 27 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 3 1930 to Oct - 27 - 1930  
that I last saw h. en alive on Oct - 27 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
Chronic Endocarditis

(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) B. J. Brinson M. D.  
10/27 1930 (Address) Port Republic, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Christy Rural Cem. DATE OF BURIAL Oct 31 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Cerrville, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Cool mink*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 5 1930

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit, Md. (No. 101-2)

2 FULL NAME Mahlon Krumham Mulnix

09129 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6. DATE OF BIRTH Sept 27, 1855  
(Month) (Day) (Year)

7. AGE 74 yrs. 10 mos. 25 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) day

9. BIRTHPLACE (State or country) Iowa

10. NAME OF FATHER Eli Mulnix

11. BIRTHPLACE OF FATHER (State or country) New York

12. MAIDEN NAME OF MOTHER Restimonia Krumham

13. BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva E. Mulnix

(Address) Port Deposit, Md.

15. Filed 8/22 1930 L. J. Sanden Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August - 21, 1930  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended the deceased from Aug-17 1930 to Aug 21 1930  
that I last saw him alive on Aug 21 1930

and that death occurred on the date stated above, at 6:30 A. M.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) 4 yrs. mos. ds.

Contributory  
Secondary

(Signed) C. J. Benson M. D.  
8/21 1930 (Address) Port Deposit, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Johnell Cem DATE OF BURIAL Aug 23 1930

20. UNDERTAKER Lee A. Patterson ADDRESS Port Deposit, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH County <u>Cecil</u>			01546 58-a			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Bay View</u> (No. _____)			St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Lindley C. Murray</u>			Registration Dist. No. <u>94</u>					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)						
6 DATE OF BIRTH <u>June 8, 1866</u> (Month) (Day) (Year)								
7 AGE <u>63 yrs. 8 mos. 16 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>md</u>								
PARENTS								
10 NAME OF FATHER <u>John C. Murray</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Penna</u>								
12 MAIDEN NAME OF MOTHER <u>Hannah M. Jeffers</u>								
13 BIRTHPLACE OF MOTHER (State or Country) <u>Del</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs L. C. Murray</u> (Address) <u>North East, Md</u>								
15 Filed <u>2-25-30</u> 192 <u>Geo W. Queens</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>Feb. 23, 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 21, 1930</u> to <u>Feb 23, 1930</u> that I last saw him alive on <u>Feb 23, 1930</u> and that death occurred on the date stated above, at <u>8:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pericious Anaemia</u> (Duration) <u>4</u> yrs. ____ mos. ____ ds. Contributory Secondary _____ (Signed) <u>C. J. Stevens</u> M. D. <u>Feb 24, 1930</u> (Address) <u>North East, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Friends Cemetery Calver</u>						DATE OF BURIAL <u>Feb 26, 1930</u>		
20 UNDERTAKER <u>Joseph R. Grant</u>						ADDRESS <u>North East Md</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			02833		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u> Cecil </u>			74-0		Registration Dist. No. <u> 96 </u>	
Village or City <u> Pot. Defuit. </u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u> William J. Murray </u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u> M </u>	4 COLOR OR RACE <u> W </u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u> Married </u> (Write the word)				
6 DATE OF BIRTH <u> July 5, 1860 </u> (Month) (Day) (Year)						
7 AGE <u> 70 </u> yrs. <u> 4 </u> mos. <u> 4 </u> ds. or <u> LESS than 1 day </u> hrs. min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u> Blacksmith </u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u> Pot. Defuit. </u>						
PARENTS	10 NAME OF FATHER <u> Joseph Murray </u>					
	11 BIRTHPLACE OF FATHER (State or country) <u> Ireland </u>					
	12 MAIDEN NAME OF MOTHER <u> Mary Donnelly </u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u> Ireland </u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u> Mrs. W. J. Murray </u>						
(Address) <u> Pot. Defuit. Md. </u>						
15 Filed <u> 3/10 </u> 19 <u> 30 </u> <u> J. F. Sanders </u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u> Mar 9, 1920 </u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u> Jan 1920 </u> to <u> Mar 9, 1920 </u> , that I last saw him alive on <u> Mar 8, 1920 </u> , and that death occurred on the date stated above, at <u> 4 a.m. </u>						
The CAUSE OF DEATH * was as follows: <u> Cerebral apoplexy </u> (Duration) <u> 6 </u> yrs. <u> 6 </u> mos. <u> 6 </u> ds.						
Contributory Secondary <u> Arteriosclerosis </u> (Duration) <u> 3 </u> yrs. <u> 6 </u> mos. <u> 6 </u> ds.						
(Signed) <u> W. J. Gay </u> M. D. <u> Mar 9, 1920 </u> (Address) <u> Pot. Defuit. Md. </u>						
*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u> 3 </u> yrs. <u> 6 </u> mos. <u> 6 </u> ds. In the State <u> 3 </u> yrs. <u> 6 </u> mos. <u> 6 </u> ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u> Mt. Erie Cemetery </u>						DATE OF BURIAL <u> Mar 11, 1920 </u>
20 UNDERTAKER <u> Cunningham &amp; Son </u>						ADDRESS <u> Edelsburg, Md. </u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Mesles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *puerperal*, "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 8 1920  
BUREAU

N B--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Elkton Cecil</u>			Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. _____)			St. _____	Ward _____
2 FULL NAME <u>Mary Alice Musson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>April 10 1923</u> (Month) (Day) (Year)				
7 AGE <u>6</u> yrs. <u>11</u> mos. <u>30</u> ds. or _____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
10 NAME OF FATHER <u>Richard Musson Jr</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
12 MAIDEN NAME OF MOTHER <u>Theresa Foraker</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr Richard Musson</u> (Address) <u>Elkton, Md</u>				
15 Filed <u>Apr 10</u> 192 <u>30</u> <u>Frank H. Tracer</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>April 9<sup>th</sup></u> 192 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 7</u> 192 <u>30</u> to <u>April 9</u> 192 <u>30</u> that I last saw him alive on <u>April 9<sup>th</sup></u> 192 <u>30</u> and that death occurred on the date stated above, at <u>12:00</u> m. <u>N.</u>				
The CAUSE OF DEATH * was as follows: <u>Diphtheria</u> (Duration) _____ yrs. _____ mos. <u>7</u> ds.				
Contributory Secondary _____				
(Signed) <u>James J. Greenleaf</u> M. D. 192 <u>30</u> (Address) <u>Elkton</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Cemetery</u>			DATE OF BURIAL _____, 19 <u>30</u>	
20 UNDERTAKER <u>A. J. Chemist</u>			ADDRESS <u>Elkton, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acidul;* *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A check data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 7 1910  
BUREAU V



MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton

2 FULL NAME Wm Franklin Murphy

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 10, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 0 moa. 28 ds. or 1 day 25 hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Captain  
(b) General nature of industry business, or establishment in which employed or (employer) Barge Southern Railway Co

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Wm Murphy

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER No information

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm F. Murphy  
(Address) Chesapeake City Md

15 Filed June 9, 1930 J. Frank Taylor Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 8, 1930 to June 8, 1930, that I last saw him alive on June 8, 1930, and that death occurred on the date stated above, at 4:25 P. m. The CAUSE OF DEATH \* was as follows:

Coronary Occlusion

Contributory Secondary Chronic myocarditis  
(Duration) 3 yrs. 1 mo. 1 ds.

(Signed) J. Frank Taylor M. D.  
1930 (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 1 mo. 1 ds. In the State 3 yrs. 1 mo. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL June 11, 1930

20 UNDERTAKER H. W. Phipps ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 8 1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Ebelin (No.         )

2 FULL NAME Heff - Born 6'3" in Cecil 6'3" in

02834  
(162)  
STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Mar 9 / 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 20 min.?  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil Co Md

10 NAME OF FATHER Heber Heff

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Maie Dunbar

13 BIRTHPLACE OF MOTHER (State or Country) Wilmington

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Heber Heff  
(Address) Wilmington

15 Filed Mar 9 1930 John H. Hager Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 4 / 1930 to Mar 9 / 1930, that I last saw him alive on Mar 9 / 1930, and that death occurred on the date stated above, at 6:30 P.M.  
The CAUSE OF DEATH \* was as follows:

Congenital Atelectasis  
(Duration) 20 hours yrs. mos. ds.

Contributory Secondary  
(Signed) D. A. Campbell M. D.  
Mar 9 / 1930 Address Wilmington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bridgetown Md ADDRESS Bridgetown Md  
20 UNDERTAKER John J. Wilson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Beecil</u>		02835 (46)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Perry Point</u> (No. _____)		St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Helan Elizabeth Neil</u>		Registration Dist. No. <u>96</u>		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR-DIVORCED (Write the word) <u>married</u>		
6 DATE OF BIRTH <u>Sept 14 1874</u> (Month) (Day) (Year)				
7 AGE <u>55 yrs. 5 mos. 27 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Moran Pa.</u>				
PARENTS	10 NAME OF FATHER <u>Abraham Preston Pew.</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Elizabeth Haines</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Pa.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>T. H. Neil</u> (Address) <u>Perry Point, Md.</u>				
15 Filed <u>3/11/1930</u> <u>L. F. Sanders</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>March 10 1930</u> <u>March</u> (Month) <u>10</u> (Day) (Year) <u>1930</u>				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Oct 15 1928</u> to <u>March 10 1930</u> , that I last saw him alive on <u>March 10 1930</u> , and that death occurred on the date stated above, at <u>8.40 P</u> m. The CAUSE OF DEATH * was as follows: <u>Carcinoma of Cervix</u>				
(Duration) <u>1 yrs. 6 mos.</u> ds.				
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>Lester W. Day</u> M. D. <u>March 10 1930</u> (Address) <u>Perry Point Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Perry Point Md</u>			DATE OF BURIAL <u>March 13 1930</u>	
20 UNDERTAKER <u>Pennington &amp; Son</u>			ADDRESS <u>Harve &amp; Grace</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* "the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1922  
BUREAU V. S.

WRITE ABOVE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		185 10301		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		Registration Dist. No. <u>92</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Nesbitt</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u>			
6 DATE OF BIRTH <u>Nov 20<sup>th</sup> 1882</u> (Month) (Day) (Year)					
7 AGE <u>47</u> yrs. <u>10</u> mos. <u>29</u> ds. or min. If LESS than 1 day hrs. 29					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>S. C.</u>					
10 NAME OF FATHER <u>Solomon Nesbitt</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>S. C.</u>					
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Etta Nesbitt</u> (Address) <u>Elkton, Md. R. 2</u>					
15 Filed <u>Sept 20 1930</u> <u>Frank Taylor</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 19<sup>th</sup> 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>9/19/30</u> 192... to <u>9/19/30</u> 192... that I last saw him alive on <u>9/19/30</u> 192... and that death occurred on the date stated above, at <u>10:30 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Fractured cervical vertebra</u> (Duration) yrs. mos. ds.					
Contributory <u>fall from ladder</u> Secondary <u>accidental</u> (Duration) yrs. mos. ds.					
(Signed) _____ M. D.					
192... (Address) <u>Elkton, Md.</u>					
* State the disease causing death in deaths from Violent Cause, state the Means of Injury and (b) Whether Accidental, Suicide or Homicide.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. <u>6</u> In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence <u>Elkton R. 2</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Parkers Ferry</u>				DATE OF BURIAL <u>Sept 24, 1930</u>	
20 UNDERTAKER <u>H. W. Pippin</u>				ADDRESS <u>Elkton Md</u>	

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930  
BUREAU

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1 PLACE OF DEATH  
County CECIL

02836 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City U. S. Veterans' Hospital, Perry Point, Maryland, St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME NICK, Carl C-None

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH November 20, 1898  
(Month) (Day) (Year)

7 AGE 31 yrs. 3 mos. 26 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country) Monaca, Pa.

10 NAME OF FATHER Joseph Nick

11 BIRTHPLACE OF FATHER  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Anna Engel,

13 BIRTHPLACE OF MOTHER  
(State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records, U.S. Veterans' Hosp.,

(Address) Perry Point, Maryland.

15 Filed 3/17 1930 Charles C. Morrison  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from November 23, 1928 to March 16, 1930

that I last saw him alive on March 16, 1930

and that death occurred on the date stated above, at 9:45 A. M.

The CAUSE OF DEATH \* was as follows:

Tuberculosis, Pulmonary Chronic, Advanced Active, Type C.

Approximately 5 years.  
(Duration) yrs. mos. ds.

Contributory, Dementia Praecox, Catatonic Type  
Secondary

Approximately 6 years.  
(Duration) yrs. mos. ds.

(Signed) F. E. LESLIE, Medical Officer in Charge M. D.  
March 17, 1930 (Address) U.S.V.H. Perry Point, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 3 mos. 23 ds. In the State 1 yrs. 3 mos. 23 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Monaco, Pa.

19 PLACE OF BURIAL OR REMOVAL Batchelor Bros., Monaca, Pa. DATE OF BURIAL March 19, 1930

20 UNDERTAKER Pennington & Son, Havre de Grace, Maryland. ADDRESS Pennington & Son, Havre de Grace, Maryland.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*. *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1930  
BUREAU OF



WRITE ALWAY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Cecil

04169

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 790Village or City Principio Furnace (No. 1)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Clara Alice Nickle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single6 DATE OF BIRTH January 17, 1927  
(Month) (Day) (Year)7 AGE 3 yrs. 2 mos. 23 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Perry Cooley Nickle11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Clara Amelia Wilson13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry C. Nickle(Address) Principio Furnace15 Filed Apr 22 1930  
John M. Montgomery Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 10

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 10th, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 4, 1930 to April 10, 1930, that I last saw her alive on April 10, 1930, and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH \* was as follows:

Broncho - Pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.Contributory  
Secondary(Signed) J. F. Magraw M. D.  
4/10 1930 (Address) Perryville Md

\*State the Disease Causing Death, if in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of des.h? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hopewell, Md.April 13 1930

20 UNDERTAKER

ADDRESS

J. C. TysonResiding

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tyraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 2 1920  
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

05441

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91Village or City Chesapeake City (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Howland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>m</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____
-------------------	---------------------------------	---

6 DATE OF BIRTH May 21st, 1920  
(Month) (Day) (Year)7 AGE 3 yrs. 3 mos. 0 ds. or 0 min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)Cecil, Maryland10 NAME OF FATHER Wm Howland11 BIRTHPLACE OF FATHER  
(State or country) Chesapeake City, Md.12 MAIDEN NAME OF MOTHER Clara Nelson13 BIRTHPLACE OF MOTHER  
(State or country) Chesapeake City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Howland(Address) Ches. City15 Filed 5/28 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21st, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 21st, 1920 to May 21st, 1920  
that I last saw him alive on May 21st, 1920and that death occurred on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH \* was as follows:

Premature birthContributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) James J. Small M. D.  
1920 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL \_\_\_\_\_, 19\_\_\_\_

20 UNDERTAKER ADDRESS \_\_\_\_\_

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUN 4 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>RD</u> )		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Mary J. O'Connor</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)	
6 DATE OF BIRTH <u>Oct 20</u> , 18 <u>64</u> (Month) (Day) (Year)			
7 AGE <u>65</u> yrs. <u>9</u> mos. <u>11</u> ds. or <u>11</u> min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>			
10 NAME OF FATHER <u>John Donahue</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>			
12 MAIDEN NAME OF MOTHER <u>Josephine Hogue</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pennsylvania</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Martha Vander</u> (Address) <u>North East Md</u>			
15 Filed <u>July 31</u> 192 <u>0</u> <u>John H. Hays</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>July 31</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>1920</u> to <u>1920</u> , that I last saw <u>her</u> alive on <u>7/31</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>11 P.</u> m. The CAUSE OF DEATH * was as follows: <u>From information</u> <u>Cancer of Stomach</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory Secondary (Signed) _____ M. D. (Address) <u>1920</u> *State the Disease causing Death, or the deaths from Violent Causes, state the Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence 19 PLACE OF BURIAL OR REMOVAL <u>Phila Pa</u> DATE OF BURIAL <u>Aug 2</u> , 19 <u>30</u> 20 UNDERTAKER <u>H. W. Pippin</u> ADDRESS <u>Elkton Md</u>			



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statement of OCCUPATION is very important. See instructions on back of certificate.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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MAY 7 1930

BURIAL

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1 PLACE OF DEATH County <u>Cecil</u>		0344		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Principio Furnace</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>David Harvey Owens</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 6</u> , 18 <u>53</u> (Month) (Day) (Year)					
7 AGE <u>76</u> yrs., <u>3</u> mos., <u>14</u> ds. or <u>LESS</u> than 1 day ____ hrs. ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Retired 10 years.</u>					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
10 NAME OF FATHER <u>William F. Owens</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>					
12 MAIDEN NAME OF MOTHER <u>Annie E. Baker</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. S. McCullough</u> (Address) <u>Principio Furnace, Ind.</u>					
15 Filed <u>JAN 27 1930</u> 192 <u>9</u> <u>L. F. Sanders</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>January 27<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>January 27</u> , 19 <u>30</u> , to <u>January 27</u> , 19 <u>30</u> , that I last saw him alive on <u>January 27</u> , 19 <u>30</u> , and that death occurred on the date stated above, <u>8.30 a.</u> m. The CAUSE OF DEATH * was as follows: <u>Atheromata</u> (Duration) <u>8</u> yrs. ____ mos. ____ ds. Contributory <u>Apoplexy</u> Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>J. F. Magraw</u> M. D. <u>Jan. 27, 1930</u> (Address) <u>Ferryville Ind.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Principio Cem.</u> DATE OF BURIAL <u>Jan. 30</u> , 19 <u>30</u>					
20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Ferryville Ind.</u>					

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			13705		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u> Cecil </u>			(14)		Registration Dist. No. <u> 96 </u>	
Village or City <u> Port Deposit </u> (No. _____)			St. _____		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u> Hester A. Owens </u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u> Female </u>	4 COLOR OR RACE <u> Colored </u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u> Married </u> (Write in detail)				
6 DATE OF BIRTH <u> Jan. 1, 1876 </u> (Month) (Day) (Year)						
7 AGE <u> 54 </u> yrs. <u> 10 </u> mos. <u> 2 </u> ds. or min. If LESS than 1 day ____ hrs.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u> House work </u> (b) General nature of industry, business, or establishment in which employed or (employed) <u> Tongue School </u>						
9 BIRTHPLACE (State or country) <u> Md. </u>						
PARENTS	10 NAME OF FATHER <u> John Henry </u>					
	11 BIRTHPLACE OF FATHER (State or country) <u> Md. </u>					
	12 MAIDEN NAME OF MOTHER <u> Hannah Lynmore </u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u> Md. </u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u> James A. Owens </u> (Address) <u> Port Deposit, Md. </u>						
15 Filed <u> 11-11 </u> 19 <u> 30 </u> <u> L. H. Sanders </u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u> Nov-3- </u> , 19 <u> 30 </u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u> Oct-24 </u> 19 <u> 30 </u> to <u> Nov-3 </u> 19 <u> 30 </u> that I last saw her alive on <u> Nov-3 </u> 19 <u> 30 </u> and that death occurred on the date stated above, at <u> 2:30 </u> p.m. The CAUSE OF DEATH * was as follows: <u> Acute Ulcerative Enteritis </u> (Duration) ____ yrs. ____ mos. <u> 20 </u> ds.						
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.						
(Signed) <u> B. J. Benson </u> M. D. <u> 11/24 </u> 19 <u> 30 </u> (Address) <u> Port Deposit, Md. </u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u> Chestbury Cem. </u>						DATE OF BURIAL <u> Nov-6- </u> 19 <u> 30 </u>
20 UNDERTAKER <u> Les A. Patterson </u>						ADDRESS <u> Perryville, Md. </u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

13706

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake City (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Woodlyn Parris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct 4, 1878  
(Month) (Day) (Year)

7 AGE 52 yrs. 1 mos. 6 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Manager  
(b) General nature of industry, business, or establishment in which employed or (employer) Farmer

9 BIRTHPLACE (State or country) Caroline Co., Md.

10 NAME OF FATHER Geo. W. Parris

11 BIRTHPLACE OF FATHER (State or country) Caroline Co., Md.

12 MAIDEN NAME OF MOTHER Mary E. Mitchell

13 BIRTHPLACE OF MOTHER (State or Country) Caroline Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) DD Jones  
(Address) Chesapeake City,

15 Filed 11/11 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 10, 1930  
Eleventh (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 28 1930 to Nov 9, 1930, that I last saw him alive on Nov 8, 1930,

and that death occurred on the date stated above, at 4 P.M. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of mandible and neck

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Secondary Metastasis

(Signed) CHD Jones M. D.  
Nov 10 1930 (Address) Chesapeake City, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Palmy Cemetery DATE OF BURIAL Nov 13 1930

20 UNDERTAKER John H. Caffage ADDRESS Esilton Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 4 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations by Committee on cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Near Chesapeake City

2 FULL NAME Mary E. Parris

04171

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH 2 / 1 / 1848  
(Month) (Day) (Year)

7 AGE 82 yrs. 3 mos. — ds. or — min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Ch. House  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER Jessie Mitchell

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Caroline McKee

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed May 2 19230 B. Howard Brown Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 24, 1930 to April 30, 1930, that I last saw him alive on April 27, 1930,

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:  
Cerebral hemorrhage

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.  
arterio sclerosis

(Signed) H. D. Morrison M. D.  
May 1, 1930 (Address) Elkton, Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Grasshopper Cemetery DATE OF BURIAL May 4, 1930

20 UNDERTAKER John H. Coffage ADDRESS Cecilton, Ind.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstian, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville (No. )

2 FULL NAME John L. Patterson

09130

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male  
4 COLOR OR RACE white  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
6 DATE OF BIRTH July 29, 1862  
7 AGE 68 yrs. 30 mos. 30 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed or (employer) Contractor

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Geo. K. Patterson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Kelley

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L. Patterson  
(Address) Perryville, Md.

15 Filed 8/30 1930 L. Bander Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 1st 1928 to August 27, 1930, that I last saw him alive on August 27, 1930.

and that death occurred on the date stated above, at 10:40 P. M.  
The CAUSE OF DEATH \* was as follows:

Chronic Valvular Heart Disease

(Duration) 5 yrs. mos. ds.  
Contributory Secondary Apoplexy

(Signed) J. F. Magraw M. D.  
Aug. 29, 1930 (Address) Perryville Md.

States the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) \*

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Cemetery Aug 30, 1930

20 UNDERTAKER ADDRESS  
John L. Patterson Perryville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil07915 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME PATTON, Dixon Civil War Vet.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH <u>August 4, 1844</u> (Month) (Day) (Year)
--

7 AGE <u>85 yrs. 11 mos. 23 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
--	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____
--

9 BIRTHPLACE (State or country) <u>Enterprise, W. Va.</u>
--

10 NAME OF FATHER <u>George Patton</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>West Virginia.</u>
---

12 MAIDEN NAME OF MOTHER <u>Unknown</u>
--

13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1 Hospital Records,(Address) Perry Point, Md.15 Filed July 28, 1930 Charles W. Madison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 23, 1928 to July 27, 1930.that I last saw him alive on July 27, 1930.and that death occurred on the date stated above, at 1:50 A.M.

The CAUSE OF DEATH \* was as follows:

1. Carcinoma of the stomach involving liver, pancreas and pylorus.2. Senility.Duration: 1 & 2 - Unknown.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) F. B. LESLIE M. D. Officer in Charge.  
July 28, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 1 mos. 4 ds. In the State Unknown mos. \_\_\_\_ ds. \_\_\_\_Where was disease contracted, if not at place of death? UnknownFormer or usual residence 717 Walnut St., Fairmont, W. Va.19 PLACE OF BURIAL OR REMOVAL R. C. Jones, Funeral Director, Fairmont, W. Va. DATE OF BURIAL July 30, 1930.20 UNDERTAKER R. Madison Mitchell, Hayre de Grace, Md. ADDRESS R. Madison Mitchell

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N B.--Every item of information should be carefully supplied AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Berk

WITHIN CORPORATE LIMITS OF

04172

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Berkton (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Morris C. Potts

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 16 1909  
(Month) (Day) (Year)

7 AGE 70 yrs. 10 mos. 26 ds. or 26 min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Fire work  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Frank Potts11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Helen Hammond13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs James Hammond(Address) Berkton, Md15 Filed Apr 14 1920 Frank Boyer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from March 1 1920 to April 9 1920, that I last saw him alive on April 8 1920 and that death occurred on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Tumor  
Benign. cereb. os.  
(Duration) ✓ yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) James Hammond M. D.  
1920 (Address) Berkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. .... mos. .... ds. In the State \_\_\_\_ yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cherry Hill Cemetery DATE OF BURIAL April 14 1920  
20 UNDERTAKER G. J. Chenevix ADDRESS Berkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiorenal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 7 1930  
BUREAU V

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Cecilton (No. \_\_\_\_\_)

2 FULL NAME Mary E. Pearce

09131 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 11 9 1893  
(Month) (Day) (Year)

7 AGE 74 yrs. 9 mos. 19 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co., Md.

10 NAME OF FATHER J. E. Hargreaves

11 BIRTHPLACE OF FATHER (State or country) Cecil Co., Md.

12 MAIDEN NAME OF MOTHER M. E. Jones

13 BIRTHPLACE OF MOTHER (State or country) Cecil Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Pearce

(Address) Cecil Co.

15 Filed 8-30 1930 J. H. Norman  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1930 to Aug 28, 1930  
that I last saw her alive on Aug 20, 1930

and that death occurred on the date stated above, at 3 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) Indefinite yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) L. K. Jones M. D.  
Aug 29, 1930 (Address) Salmon, Md.

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cecilton Cemetery DATE OF BURIAL Aug 30, 1930

20 UNDERTAKER John H. Caffage ADDRESS Cecilton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH  
County Cecil

02837

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

Village or City Port Deposit (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hannah Mary Peoples

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH January 3, 1850  
(Month) (Day) (Year)

7 AGE 80 yrs. 2 mos. 19 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert Rawlings

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Key

13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Idie M. White

(Address) Port Deposit Md.

15 Filed 3-21-1930 Registrar George W. Warrington

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 19 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2-1-1930 to 3-19-1930  
that I last saw him alive on 3-4-1930

and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH \* was as follows:

General Debility  
Arteriosclerosis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Reed D. Johnson M.D.  
3/20 1930 (Address) Port Deposit

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Nottingham Ind. DATE OF BURIAL Mar 22, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Prising Sun, Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 3-21-1930



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930

BUREAU

RECEIVED

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cal

Village or City North East (No. RD 2)

2 FULL NAME Sally Pennick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 12, 1886  
(Month) (Day) (Year)

7 AGE 44 yrs. 2 mos. 5 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER no information

13 BIRTHPLACE OF MOTHER (State or Country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Pennick  
(Address) North East md

15 Filed 9/19/30 Geo. W. C. C. C. Registrar

10302

7142

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept - 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 16, 1930 to Sept 17, 1930  
that I last saw her alive on Sept 16, 1930

and that death occurred on the date stated above, at 2A m.  
The CAUSE OF DEATH \* was as follows:

Apoplexy

Contributory Arterio Sclerosis  
Secondary

(Signed) O. H. Hall M. D.  
Sept 19, 1930 Address North East md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death hrs. mos. ds. In the State hrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL A. W. M. P. Cemetery DATE OF BURIAL Sept 20, 1930

20 UNDERTAKER Joseph P. Hunt ADDRESS North East md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescal*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescal* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 2 1910

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Cokebury (No. \_\_\_\_\_)

2 FULL NAME Premature Infant Perkins

13707 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov. 20, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or 10 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Wm. Henry Perkins

11 BIRTHPLACE OF FATHER (State or country) Arkansas

12 MAIDEN NAME OF MOTHER Lillian Banke

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian Perkins

(Address) Port Deposit B. & O.

15 Filed 11/21, 1930 L. F. Sanders  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 20, 1930 to Nov. 20, 1930, that I last saw him alive on Nov. 20, 1930, and that death occurred on the date stated above, at 3:10 P. m. The CAUSE OF DEATH \* was as follows:

Premature Birth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. F. Magan M. D.  
Nov. 20, 1930 (Address) Permyville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Our Premises DATE OF BURIAL Nov. 20, 1930

20 UNDERTAKER Wm. H. Perkins (Father) ADDRESS Port Deposit B. & O.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

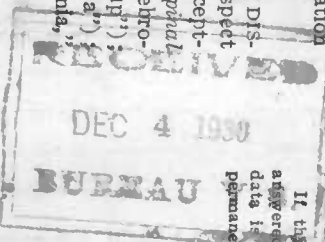
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; L. Shoptumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by running train—accident; Renalr wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions ascertained in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





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1 PLACE OF DEATH County <u>Cecil</u>		10303 198		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		Registration Dist. No. <u>92</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Perry</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>2nd</u> <u>10</u> <u>1901</u> (Month) (Day) (Year)					
7 AGE <u>29</u> yrs. <u>6</u> mos. <u>16</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Georgia</u>					
10 NAME OF FATHER					
11 BIRTHPLACE OF FATHER (State or country) <u>information</u>					
12 MAIDEN NAME OF MOTHER					
13 BIRTHPLACE OF MOTHER (State or Country) <u>no</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edward Moss</u> (Address) <u>Glasgow Del.</u>					
15 Filed <u>Sept 29</u> 19 <u>30</u> <u>J. Frank Taylor</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept. 26</u> 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>9/26</u> 19 <u>30</u> that I last saw him <u>dead</u> <u>live on</u> <u>9/26</u> 19 <u>30</u> and that death occurred on the date stated above, at <u>5:15 A.</u> m. The CAUSE OF DEATH * was as follows: <u>From information -</u> <u>Homicide occurring in Delaware. cause of</u> <u>hemorrhage resulting</u> <u>from a stab wound</u> <u>in arm</u> <u>Died in Union</u> <u>Hospital, Elkton.</u> (Duration) <u>5</u> yrs. <u>6</u> mos. <u>16</u> ds. (Signed) <u>M. D.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Delaware</u>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>5</u> yrs. <u>6</u> mos. <u>16</u> ds. In the State <u>5</u> yrs. <u>6</u> mos. <u>16</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>Delaware</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Glasgow Del.</u> <u>Colonel</u> <u>Crematorium</u>				DATE OF BURIAL <u>Sept 29</u> 19 <u>30</u>	
20 UNDERTAKER <u>J. W. Whippin</u>				ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a full question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930  
BUREAU OF VITALS

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital) St. III-a Ward 92

2 FULL NAME Bertha Peterson

05442 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH May 22, 1900  
(Month) (Day) (Year)

7 AGE 30 yrs. 0 mos. 7 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER no information

11 BIRTHPLACE OF FATHER (State or country) no information

12 MAIDEN NAME OF MOTHER no information

13 BIRTHPLACE OF MOTHER (State or country) no information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George E Peterson  
(Address) Elkton Md RD

15 Filed June 2, 1930 Registrar J. Frank Taylor

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from May 26, 1930 to May 29, 1930, that I last saw her alive on May 29, 1930

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH \* was as follows:

Ruptured gastric ulcer

Contributory  
Secondary

(Duration)        yrs.        mos.        ds.  
(Signed) Herbert Bales M. D.  
5730 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos. 3 ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

June 2, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by runaway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLACE OF DEATH

County

Cecil

13708

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Elkton

(No.)

Md. Union Hospital

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Phillips, Mattie A. G.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 17, 1886  
(Month) (Day) (Year)

7 AGE

74 yrs. 3 mos. 25 ds. If LESS than  
1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Ellis Phillips

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann Beaman

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellis Cunningham

(Address)

2029 Cold Spring Lane, Baltimore, Md.

15 Filed

Nov 13 1930 J. H. Hays

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 12, 1930  
November (Month) 12 (Day) 1930 (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 2 1930 to Nov 12 1930

that I last saw him alive on

Nov 12 1930

and that death occurred on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Herbert H. Bates, M. D.  
11/12 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 10 ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Newark, Delaware

Former or usual residence

264 E. Main St. Newark, Del.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crompton Mass

Nov 15, 1930

20 UNDERTAKER

ADDRESS

R. V. Jones

Baltimore



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal fever"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tetionaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930  
BUREAU V.S.

MARGIN RESERVED FOR BINDING. WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <u>Cecil</u>		CERTIFICATE OF DEATH	
Village or City <u>near Cecil</u>		Registration Dist. No. <u>90</u>	
2 FULL NAME <u>Lillian Poore</u>		St. <u>2nd Light</u> Ward <u>2nd Light</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	
6 DATE OF BIRTH <u>9</u> <u>14</u> <u>1900</u> (Month) (Day) (Year)			
7 AGE <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Cecil Co. Ind.</u>			
10 NAME OF FATHER <u>Geo. W. Poore</u>			
11 BIRTHPLACE OF FATHER <u>Kent Co. Ind.</u>			
12 MAIDEN NAME OF MOTHER <u>Emma Craig</u>			
13 BIRTHPLACE OF MOTHER <u>Cecil Co. Ind.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo m. Poore</u> (Address) <u>Cecil Co. Ind.</u>			
15 Filed <u>Sept. 15 1930</u> <u>J. J. Corran</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>8/28 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>8/14 1930</u> to <u>8/28 1930</u> , that I last saw him alive on <u>8/28 1930</u> , and that death occurred on the date stated above, at <u>9:00</u> m. The CAUSE OF DEATH * was as follows: <u>Pneumonia</u>			
(Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds.			
Contributory Secondary			
(Signed) <u>John H. Coffage</u> M. D.			
192 (Address) <u>Cecil Co. Ind.</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
At place of death <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. In the State <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Cecil Co. Ind.</u>		DATE OF BURIAL <u>9/16/1930</u>	
20 UNDERTAKER <u>John H. Coffage</u>		ADDRESS <u>Cecil Co. Ind.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Remover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

Village or City Kear

2 FULL NAME Lucinda Poore

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_

6 DATE OF BIRTH 9 14 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Ind.

10 NAME OF FATHER Geo. W. Poore

11 BIRTHPLACE OF FATHER (State or country) Kear Co. Ind.

12 MAIDEN NAME OF MOTHER Emmie Craig

13 BIRTHPLACE OF MOTHER (State or country) Cecil Co. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. M. Poore

(Address) Cecil Co. Md.

15 Filed Sept. 15 1930 Registrar John H. Haffage

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8/15 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 8/8/30 1930 to 8/15/30 1930, that I last saw her alive on 8/14/30 1930, and that death occurred on the date stated above, at 3:00 m.

The CAUSE OF DEATH \* was as follows:

Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) John H. Haffage M. D. Ellettsville 1930 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cecil Co. Cemetery 9/16 1930

20 UNDERTAKER ADDRESS

John H. Haffage Cecil Co. Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day hrs.

yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Sept. 15 1930

Registrar

10304

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward)

(If death occurred in  
a hospital or institution,  
give its NAME instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-keeper, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scout, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD 2)

2 FULL NAME Preston Poore

02838

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Aug 6, 1922  
(Month) (Day) (Year)

7 AGE 7 yrs. 6 mos. 19 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at school  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edwin T. Poore

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes McKratt

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin T Poore

(Address) Elkton Md

15 Filed Mch 26 1923 James Hays Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 25, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 19 1922 to March 25 1923 that I last saw him alive on March 25 1923.

and that death occurred on the date stated above, at 5:30 A m. The CAUSE OF DEATH \* was as follows:

Acute myocarditis

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. 7 of them

(Signed) James Hays M. D. 1923 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Townsend Cemetery DATE OF BURIAL Mch 26 1923

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





See letter from Maggie 4/24/31 regarding child who  
born at Hosp. m0079.

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 7 1931  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

14871

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U. S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME POPE, John A.

XC-None

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH

Unknown, 1877  
(Month) (Day) (Year)

7 AGE

53 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?If LESS than  
1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Hopwood, Pa.

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Perry Point, Md.

15

Filed 12/29/30 1930Charles W. Sweeney  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 28, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

November 13 1928 to December 28, 1930.that I last saw him alive on December 28, 1930.and that death occurred on the date stated above, at 11:05 A. M.

The CAUSE OF DEATH \* was as follows:

General Paralysis of the InsaneApproximately (Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

W. A. ELLISON, Acting Med. Off. in Ch. M. D.Dec. 29 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 1 mos. 15 ds. In the State Unknown mos. \_\_\_\_\_ ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Newell, Pa.

19 PLACE OF BURIAL OR REMOVAL

James E. Hines, Undertaker,  
California, Pa.

DATE OF BURIAL

Dec. 31, 1930.

20 UNDERTAKER

ADDRESS

R. Madison Mitchell, Havre de Grace, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU V

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City near Danwick (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)12344 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number 1)

2 FULL NAME Charles S. Price Sr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED, <u>widowed</u> WIDOWED OR DIVORCED (Write the word)
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6 DATE OF BIRTH March 2, 1856  
(Month) (Day) (Year)7 AGE 74 yrs. 7 mos. 14 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Retiring Farmer  
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER George Price11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Anabelle Morgan13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Price(Address) Danwick - Md.15 Filed Oct. 18, 1930 J. K. Rowan  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 16, 1930.  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 16, 1930.that I last saw him alive on Oct 15, 1930.and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH \* was as follows:

valvular disease of heart with general arterio-sclerosisContributory  
Secondary(Signed) Dorsey W. Lewis, M. D.  
Oct 16, 1930, (Address) Middletown - Del.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Stephens Cem. Md. DATE OF BURIAL Oct 19, 193020 UNDERTAKER W. J. Wilson ADDRESS Middletown Del

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1930

DEPT. OF HEALTH



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City (No.)

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the last)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1930

2/22

L. F. Sanders

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him live on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Apoplexy (Cerebral Hemorrhage of brain)

Contributory  
Secondary

(Signed) M. D.

2/21 1930 (Address) Liberty Corner Md.

\*State the Cause Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

20 DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 7 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated-EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

2 FULL NAME Ralph McCoy Price

6346 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (if death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Jan 19, 1893  
(Month) (Day) (Year)

7 AGE 37 yrs. 0 mos. 12 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer day  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas M. Price

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna M. McCoy

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas M. Price  
(Address) Chesapeake City, Md RD 1

15 Filed Feb 3 1930 J. Frank Page Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 20, 1930 to Jan 31, 1930, that I last saw him alive on Jan 31, 1930

and that death occurred on the date stated above, at 1:45 A. m. The CAUSE OF DEATH \* was as follows:

Eff. pneumonia due to splinter  
(Duration) yrs. mos. ds. 10 ds.

Contributory  
Secondary

(Signed) John J. [Signature] M. D.  
192 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Feb 3, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 8 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD 2)

2 FULL NAME Helen C Proctor

05443 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Apr 27 1909  
(Month) (Day) (Year)

7 AGE 21 yrs. 0 mos. 4 ds. or min.?

If LESS than 1 day \_\_\_\_ hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) Maryland

10 NAME OF FATHER Hugh S Proctor

11 BIRTHPLACE OF FATHER Virginia  
(State or country)

12 MAIDEN NAME OF MOTHER Marjorie Conley

13 BIRTHPLACE OF MOTHER Pennsylvania  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hugh S Proctor

(Address) Elkton Md RD 2

15 Filed May 14 1930

J. Frank Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 11 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 15 1930 to May 11 1930  
that I last saw her alive on May 10 1930,

and that death occurred on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH \* was as follows:

acute cardiac dilatation

(Duration) 15 min yrs. mos. ds.

Contributory Secondary Chronic myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) Arthur Bales M. D.

5712 1930 (Address) Elkton Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery

DATE OF BURIAL May 14 1930

20 UNDERTAKER W. W. Bippin

ADDRESS Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

RECEIVED

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITING IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital)

2 FULL NAME Remo John Prosperi

10307  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
6 DATE OF BIRTH Oct. 23rd, 1908 (Month) (Day) (Year)

7 AGE 21 yrs. 10 mos. 29 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Student  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Wash. D. C.

10 NAME OF FATHER Cairo Prosperi

11 BIRTHPLACE OF FATHER (State or country) Italy

12 M maiden NAME OF MOTHER Rose Coe

13 BIRTHPLACE OF MOTHER (State or Country) Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs Geo. Morris  
(Informant)  
1831-23rd St. N. W. Wash  
(Address)

15 Filed Sept 22 1930 J. Frank Hayes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 22, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 22, 1930, to Sept 22, 1930, that I last saw him alive on Sept 22, 1930,

and that death occurred on the date stated above, at 3:15 A. M.

The CAUSE OF DEATH \* was as follows:

Fractured Skull  
Hemorrhage of Brain

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory automobile accident  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Howard W. Green M.D.  
9/22/30 (Address) Elkton, Md

State the disease causing death, as in deaths from Violent Causes, state the Means of Injury and (2) Whether Accidental, Suicidal, or Criminal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1831 - 23rd St Wash D C

19 PLACE OF BURIAL OR REMOVAL Washington D C DATE OF BURIAL Sept 24, 1930

20 UNDERTAKER H. W. Prosperi ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 1913  
BUREAU



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Drepsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

12345

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles C Queck

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept 27, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 22 mos. 22 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Baker retired  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER John G. Queck

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Dorothy Schraau

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Annis Queck  
(Address) Elkton Md

15 Filed Oct 22 1930 J. Paul Jager Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from per 1929 to Oct 19, 1930

that I last saw him alive on Oct 17, 1930, and that death occurred on the date stated above, at 6 a. m.  
The CAUSE OF DEATH \* was as follows:

Acute Cardiac dilatation

(Duration) yrs. mos. ds.  
Contributory Secondary Chronic Endocarditis  
& myocarditis

(Signed) Robert Bales M. D.  
10/20 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery

Oct 22, 1930

20 UNDERTAKER

ADDRESS

H. W. Pippin

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The marital work: 1 on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930  
BUREAU

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Genee

Village or City Chesapeake City (No. ....)

2 FULL NAME Susannah Queck

14872  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Feb. 21 1856  
(Month) (Day) (Year)

7 AGE 74 yrs. 10 mos. 7 ds. If LESS than 1 day... hrs. or ... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Michael Godshall

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Queck (Daughter)  
(Address) Chesapeake City Md.

15 Filed Dec. 29 1930 B. Howard Brown Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-28-30  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 6-15-30 1930 to 12-28-30 1930

that I last saw him alive on 12-28-30 1930

and that death occurred on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH \* was as follows:  
Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.  
Contributory Secondary Atherosclerosis

(Signed) Wm. E. Van Norden M. D.  
(Address) 192

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery (Md.) DATE OF BURIAL Dec. 30<sup>th</sup> 1930

20 UNDERTAKER Harry G. Laws ADDRESS Chesapeake City Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

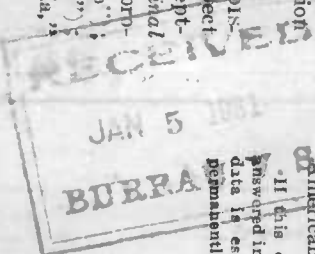
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *farmer or planter, physician, compositor, architect, locomotive engineer, civil engineer, stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like date is essential and must be obtained before the certificate is remitted.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Cherry Hill (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME John W. Quein

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Apr 11, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. - 18 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Ret. Store Super  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER Robert Quein

11 BIRTHPLACE OF FATHER (State or country) Penna

12 MAIDEN NAME OF MOTHER Emilie Morrison

13 BIRTHPLACE OF MOTHER (State or Country) Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mabel Lutz  
(Address) Elkton RD #5 md

15 Filed May 1 1930 C. S. Grant  
Registrar

04790

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 93

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1 1930 to April 29 1930, that I last saw him alive on April 29, 1930, and that death occurred on the date stated above, at 5:00 p.m. The CAUSE OF DEATH \* was as follows:

Cerebral embolism.

Contributory Secondary Calcium nephritis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) James J. Cunningham M. D.  
1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Sharps Cemetery md DATE OF BURIAL May 1, 1930

20 UNDERTAKER C S Grant & Son ADDRESS Elkton RD #5



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 3 1950

BURE

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

07916

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City Near Bay View (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Albert D. Racine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widower</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH June 12, 1882  
(Month) (Day) (Year)7 AGE 78 yrs. 1 mos. 3 ds. or 1 day 1 hrs. 1 min.?  
If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Del10 NAME OF FATHER John F. Racine11 BIRTHPLACE OF FATHER (State or country) France12 MAIDEN NAME OF MOTHER Annie Ross13 BIRTHPLACE OF MOTHER (State or Country) Del

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Racine  
(Address) North East Rd. Md.15 Filed 7-16-30 1930 Eugene Racine  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 15 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from March 30, 1929 to July 15, 1930  
that I last saw him alive on July 15, 1930  
and that death occurred on the date stated above, at 2052 in.  
The CAUSE OF DEATH \* was as follows:  
Congestive  
Heart FailureContributory  
Secondary(Signed) Eugene Racine M.D.  
7-16-30 (Address) Princeton, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Dover Rd. Silver Lake DATE OF BURIAL July 18, 193020 UNDERTAKER Joseph R. Hunt ADDRESS North East Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City Elkton(No. Union Hospital)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Daisy Dora Radcliff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH June 10, 1930

(Month)

(Day)

(Year)

7 AGE

2 yrs. 2 mos. 26 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country) Maryland10 NAME OF FATHER Carl Radcliff11 BIRTHPLACE OF FATHER Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hogwood13 BIRTHPLACE OF MOTHER Virginia

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Radcliff(Address) Elkton Md15 Filed June 7, 1930J. M. H. Hays

Registrar

20 UNDERTAKER H. W. Pippin

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1930(Month) 6 (Day) 19 (Year) 193017 I HEREBY CERTIFY, That I attended the deceased from June 4<sup>th</sup> 1930 to June 6<sup>th</sup> 1930that I last saw him alive on June 5<sup>th</sup> 1930and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH \* was as follows:

Relapsing Cough(Duration) Unknown yrs. mos. ds.Contributory  
Secondary(Duration) Unknown yrs. mos. ds.(Signed) T. J. McLaughlin M. D.6-6-30 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death Unknown yrs. mos. ds.In the State Unknown yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Elkton CemeteryDATE OF BURIAL June 7, 193020 UNDERTAKER H. W. PippinADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Carpenter, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Irritation," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 8 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSISCIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

2 FULL NAME

09132 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed) M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of deathIn the  
StateWhere was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic; cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU U. S.

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1 PLACE OF DEATH County <u>Cecil</u>		04173 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u> (No. _____)		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>James H. Randall</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the year)	
6 DATE OF BIRTH <u>Feb 28 1868</u> (Month) (Day) (Year)			
7 AGE <u>62</u> yrs. <u>1</u> mos. <u>13</u> ds. If LESS than 1 day ____ hrs. or ____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Butler</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Private Home</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>William Randall</u>			
11 BIRTHPLACE OF FATHER <u>md</u>			
12 MAIDEN NAME OF MOTHER <u>Elizabeth Whittington</u>			
13 BIRTHPLACE OF MOTHER <u>md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James H. Randall</u> (Address) <u>Port Deposit, md.</u>			
15 Filed <u>4/12</u> 19 <u>30</u> Registrar _____			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>April 10 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 1</u> 19 <u>29</u> to <u>Dec 10</u> 19 <u>29</u> . that I last saw <u>him</u> live on <u>Dec 9</u> 19 <u>29</u> , and that death occurred on the date stated above, at <u>2 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic Valvular disease of heart</u> (Duration) ____ yrs. <u>4</u> mos. <u>10</u> ds.			
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.			
(Signed) <u>Ernest Portland</u> M. D. <u>Apr 11 1930</u> (Address) <u>Liberty Grove Md</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.			
Where was disease contracted, if not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Cockeysburg</u>		DATE OF BURIAL <u>April 13 1930</u>	
20 UNDERTAKER <u>Lee A. Patterson</u>		ADDRESS <u>Terrapoint Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

Village or City North East (No. 90)

2 FULL NAME Still born Ray

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 22, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or Country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Ray

(Address) North East Md.

15 Filed 10-22-30 1930 Geo. W. Cuccin Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 22, 1930 to Oct 22, 1930, that I last saw him alive on Oct 22, 1930, and that death occurred on the date stated above, at 9 W. M. The CAUSE OF DEATH \* was as follows: Stillbirth

## Contributory Secondary

(Signed) James H. Cunniff M. D. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 1930 (Address) North East Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

North East M.E. Cemetery Oct 22, 1930

## 20 UNDERTAKER

## ADDRESS

Joseph R. Shaw North East Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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NOV 3 1938  
BUREAU V. S.

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1 PLACE OF DEATH County <u>Jecil,</u>		02839 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u>		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Ala S. Reid</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>January 12, 1844</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>March 23, 1923</u> (Month) (Day) (Year)	
7 AGE <u>86 yrs. 2 mos. 11 ds.</u>	If LESS than 1 day ____ hrs. 1 day ____ hrs. or ____ min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>D.C.</u>			
10 NAME OF FATHER <u>George Savage</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
12 MAIDEN NAME OF MOTHER <u>Susan Chandler</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ala S. Reid</u> (Address) <u>Port Deposit, Md</u>			
15 Filed <u>3/24</u> 19 <u>30</u> <u>L. Sanders</u> Registrar		16 MEDICAL CERTIFICATE OF DEATH 17 I HEREBY CERTIFY, That I attended the deceased from <u>July</u> 192 <u>8</u> to <u>March 23</u> 192 <u>30</u> that I last saw her alive on <u>March 23</u> 192 <u>30</u> , and that death occurred on the date stated above, at <u>7 P</u> M. The CAUSE OF DEATH * was as follows: <u>Nephritis &amp; Ecdematosis.</u> (Duration) ____ yrs. ____ mos. ____ ds. Contributory Secondary <u>old age, arteriosclerosis</u> (Duration) <u>3</u> yrs. ____ mos. ____ ds. (Signed) <u>S. A. Rutland</u> M. D. <u>March 24</u> 192 <u>3</u> (Address) <u>Port Deposit</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____		19 PLACE OF BURIAL OR REMOVAL <u>Washington, D.C.</u> DATE OF BURIAL <u>March 27</u> 192 <u>30</u>	
20 UNDERTAKER <u>Bennington</u>		ADDRESS <u>Adelphi</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

07917

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

Village or City

Rising Sun (No.)

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

George C. Reynolds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write this word)

married

6 DATE OF BIRTH

 July 10, 1846  
(Month) (Day) (Year)

7 AGE

84 yrs. 3 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

Farmer retired

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF  
FATHER

Henry Reynolds

11 BIRTHPLACE  
OF FATHER

(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Eliza More

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laura C. Reynolds

(Address)

Rising Sun Md.

15

Filed

7-11-1930

192

Registrar

Louise M. Worthington  
Permit issued 7-11-1930

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 July 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

1920 to July 17, 1930

that I last saw him alive on July 6, 1930

and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH \* was as follows:

Arteriosclerosis

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

J. E. Tyson

M. D.

7/17

1920 (Address)

Rising Sun

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brookview Md.

July 16, 1930

20 UNDERTAKER

ADDRESS

J. E. Tyson

Rising Sun Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		06621		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>		148		Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		St. <u>Union Hospital</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Gertrude Mary Reynolds</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>Sept 4</u> , 18 <u>95</u> (Month) (Day) (Year)					
7 AGE <u>34</u> yrs. <u>9</u> mos. <u>3</u> ds. or <u>IF LESS than 1 day</u> hrs. <u>min.</u>					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>					
PARENTS	10 NAME OF FATHER <u>John Cowden</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Illinois</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary W Davis</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Illinois</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Cowden Reynolds</u>					
(Address) <u>North East Md. RD 1</u>					
15 Filed <u>June 11</u> , 19 <u>30</u> <u>J. Frank Rogers</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 8</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 6</u> , 19 <u>30</u> to <u>June 8</u> , 19 <u>30</u> that I last saw him alive on <u>June 7</u> , 19 <u>30</u> and that death occurred on the day stated above, at <u>7:52 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Post. Periton. E. Clampsia</u> (Duration) <u>2</u> mos. <u>2</u> ds.					
Contributory Secondary					
(Signed) <u>W. F. Page</u> (Address) <u>Howlands Md.</u> <u>June 9</u> , 19 <u>30</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death <u>Yrs.</u> <u>mos.</u> <u>ds.</u> In the State <u>Yrs.</u> <u>mos.</u> <u>ds.</u>					
Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Cherry Hill Cnty.</u>					DATE OF BURIAL <u>June 11</u> , 19 <u>30</u>
20 UNDERTAKER <u>G. J. Aleemathay</u>					ADDRESS <u>Elkton, Md.</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. 242 W. High St. Ward)

2 FULL NAME Miscarriage Reynolds

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 10309

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 5, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. 2 If LESS than 1 day 9 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Cecil Co. Md.

10 NAME OF FATHER Chas. A. Reynolds

11 BIRTHPLACE OF FATHER (State or country) Elkton Md.

12 MAIDEN NAME OF MOTHER Marion E. Wolf

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. A. Reynolds

(Address) Elkton Md.

15 Filed Sept 6, 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at Md.  
The CAUSE OF DEATH \* was as follows:

Miscarriage  
2 months gestation  
(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.  
(Signed) Herbert B. Bate M. D.  
9/5/30 (Address) Elkton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Premises DATE OF BURIAL —, 19—

20 UNDERTAKER Parents ADDRESS —

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Cecil*  
 near *North East*

Village or City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2 FULL NAME

*Eugene Richardson*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *92*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*Unknown*

(Month) (Day) (Year)

7 AGE

*about 42 yrs.*If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Va.*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*James Carey  
North East Md*

15 Filed

*Feb 19 1923*

Registrar

16 DATE OF DEATH

*Feb. 14<sup>th</sup> 1923*

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1923 to 1923

that I last saw him alive on *2/14* 1923and that death occurred on the date stated above, at *3 P.* m.

The CAUSE OF DEATH \* was as follows:

*Acute Alcoholism  
and Exposure*

(Duration) yrs. mos. da.

Contributory  
Secondary

(Duration) yrs. mos. da.

(Signed) *Howard W. Green* M.D.*7/14 30* (Address) *Elkton Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. da.

In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*County Home Cemetery*

DATE OF BURIAL

*Feb 19, 1923*

20. UNDERTAKER

*H. W. Pippie*

ADDRESS

*Elkton Md*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on it; first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer; Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leucæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930

BUREAU

WRITE PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04174 STATE OF MARYLAND	
County <u>Cecil</u>			CERTIFICATE OF DEATH	
Village or City <u>W. East</u> (No. _____)			Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Mary A. Robinson</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>71</u>	4 COLOR OR RACE <u>B</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>May 22</u> , 18 <u>82</u> (Month) (Day) (Year)				
7 AGE <u>47</u> yrs. <u>8</u> mos. <u>10</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Ind</u>				
10 NAME OF FATHER <u>George Thompson</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>no record</u>				
12 MAIDEN NAME OF MOTHER <u>no record</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>no record</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Herman King</u> (Address) <u>Mt Pleasant, Md</u>				
15 Filed <u>Apr 4</u> 192 <u>0</u> <u>J. J. Jones</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Apr. 2</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Mar 29</u> 19 <u>30</u> to <u>Apr 2</u> , 19 <u>30</u> that I last saw her alive on <u>Apr 1</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>7:30 A</u> m. The CAUSE OF DEATH * was as follows: <u>Lobar Pneumonia</u> (Duration) _____ yrs. _____ mos. <u>6</u> ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>O. J. Stevens</u> M. D. <u>Apr 3</u> 192 <u>0</u> (Address) <u>North East, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Mt Pleasant, Cecil County, Md</u>			DATE OF BURIAL <u>Apr 6</u> , 19 <u>30</u>	
20 UNDERTAKER <u>B. J. Jones</u>			ADDRESS <u>Mt Pleasant</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pigeon, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and, children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1900  
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

WITHIN CORPORATE LIMITS OF

02840 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

widowed

6 DATE OF BIRTH

Apr

4

1865

(Month)

(Day)

(Year)

7 AGE

64

yrs.

11

mos.

20

ds.

or

min.?

If LESS than

1 day

hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

James Davis

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Louise Clayton

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Joel Simmons

(Address)

Elkton Md

15 Filed

March 26 1932 J. Frank Dyer

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 24<sup>th</sup> 1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

March 23<sup>rd</sup> 1920 to March 24<sup>th</sup> 1920that I last saw him alive on March 23<sup>rd</sup> 1920

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH \* was as follows:

acute cardiac dilatation

Contributory  
Secondary

(Duration) yrs. mos. ds.

General Debility

(Signed)

J. Frank Dyer M. D.

1920 (Address) Elkton Md

\*State the 1) Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

March 26 1932

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PLACE OF DEATH

County Cecil

(44)

06622

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Elkton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Clarissa D. Rothwell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>June 15, 1868</u> (Month) (Day) (Year)
---

7 AGE <u>62 yrs. 0 mos. 14 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry business, or establishment in which employed or (employer)
---

9 BIRTHPLACE (State or country) <u>Maryland</u>
---

10 NAME OF FATHER <u>Wm. Dickerson</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>Del.</u>
--

12 MAIDEN NAME OF MOTHER <u>Elizabeth Vail</u>
---

13 BIRTHPLACE OF MOTHER (State or Country) <u>Del.</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Rothwell(Address) Stanton, Del.15 Filed July 1, 1930 J. Frank Taylor Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 \_\_\_\_ to \_\_\_\_ 192 \_\_\_\_

that I last saw her alive on June 29, 1930

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of stomach with general metastasis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Herbert Bates M. D.  
June 30, 1930 (Address) Elkton Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elkton CemeteryJuly 2, 1930

20 UNDERTAKER

ADDRESS

H. W. PippinElkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Carroll Co.

Village or City Liberty, Maryland No. 89

2 FULL NAME Robert James Rowland

10310  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 93

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH Jan 29 1844  
(Month) (Day) (Year)

7 AGE 86 yrs. 7 mos. 7 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchant  
(b) General nature of industry business, or establishment in which employed or (employer) "

9 BIRTHPLACE (State or country) Carroll Co. Md

10 NAME OF FATHER William L. Rowland

11 BIRTHPLACE OF FATHER (State or country) Liberty, Md

12 MAIDEN NAME OF MOTHER Cassandra Hopkins

13 BIRTHPLACE OF MOTHER (State or Country) Hartford Co. - Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emmet Rowland  
(Address) Liberty, Md

15 Filed Sept 8 1930  
L. M. Worthington Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 5 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 30 1930 to Sept 5 1930, that I last saw him alive on Sept 5 1930, and that death occurred on the date stated above, at 9 A m. The CAUSE OF DEATH \* was as follows:

Angina Pectoris

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Signed) C. B. Benson M.D.  
9/6 1930 (Address) Port Deposit, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Nottingham Cemetery Sept 8, 1930

20 UNDERTAKER ADDRESS

J. E. G. T. T. T. Pring, Md

Permit issued 9-8-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**For this certificate is looked over thoroughly and a) questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.**

RECEIVED  
COI 3 190  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. <u>R D</u> )			St. _____	Ward _____
2 FULL NAME <u>Anna Belle Russell</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Dec. 23<sup>rd</sup></u> , 19 <u>20</u>	
6 DATE OF BIRTH <u>Dec 9</u> , 1 <u>867</u>			17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 1<sup>st</sup></u> 19 <u>20</u> to <u>Dec 23<sup>rd</sup></u> 19 <u>20</u>	
7 AGE <u>63</u> yrs. <u>14</u> mos. <u>14</u> ds. or min.?			that I last saw h <u>e</u> alive on <u>Dec 21<sup>st</sup></u> , 19 <u>20</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			and that death occurred on the date stated above, at <u>12</u> <u>20</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic myocarditis</u>	
9 BIRTHPLACE (State or country) <u>Maryland</u>			Contributory Secondary _____	
10 NAME OF FATHER <u>Wm H Gracey</u>			(Duration) <u>4</u> yrs. _____ mos. _____ ds.	
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>			(Signed) <u>James H. Russell</u> M. D.	
12 MAIDEN NAME OF MOTHER <u>Catharine Beers</u>			<u>DEC 24 1920</u> (Address) <u>Elkton Md</u>	
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Lillian Russell</u> (Address) <u>Elkton Md</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____	
15 Filed <u>Dec 24 1920</u> <u>James H. Russell</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Elkton Catholic Cemetery</u>	
			DATE OF BURIAL <u>Dec 26</u> , 19 <u>20</u>	
			20 UNDERTAKER <u>H. W. Pippine</u>	
			ADDRESS <u>Elkton Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-signal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation means was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 7 1931  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Anril

06623

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

94

Village or City

North East

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Walter C. Russell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July

9

1928

(Month)

(Day)

(Year)

7 AGE

1

yrs.

10

mos.

28

ds.

If LESS than

1 day \_\_\_\_ hrs.

or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Chester A Russell

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Alice E. Hamilton

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chester A Russell

(Address)

North East Md

15

Filed

6-9-30

192

Geo. W. Russell

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 6

1928

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Pneumonia

Contributory  
Secondary

(Signed)

June 8, 1928 (Address) No. 101

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bay View M.O. Cemetery June 9, 1928

20 UNDERTAKER

Joseph P. Evans

ADDRESS

North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Josephine Bonaparte Salmon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 3, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 0 mos. 14 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Wm H. Webb

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rebecca A. Smith

13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Salmon  
(Address) Elkton, Md

15 Filed May 20, 1930 J. Frank J. J. J. Registrar

05444

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1929 to May 17, 1930.

that I last saw her alive on May 17, 1930.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:  
Chronic interstitial nephritis  
and chronic myocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Herbert Bales M. D.  
5/19/30 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL May 20, 1930

20 UNDERTAKER W. W. Pippin ADDRESS Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

▲ If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1930  
BUREAU



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1 PLACE OF DEATH County <u>Cecil</u>		02841 (123)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		St.: <u>Ward)</u>		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Elizabeth Samuels</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Feb 12</u> , 1881 (Month) (Day) (Year)					
7 AGE <u>49</u> yrs. <u>1</u> mos. <u>1</u> da. or <u>LESS</u> than 1 day <u>0</u> hrs. <u>0</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
10 NAME OF FATHER <u>Thomas Samuels</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>no information</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>no information</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Samuels</u> (Address) <u>Elkton Md</u>					
15 Filed <u>March 15 1930</u> <u>J. J. J. J. J.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 13</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 12</u> , 19 <u>30</u> .. to <u>March 13</u> , 19 <u>30</u> .. that I last saw her alive on <u>March 13</u> , 19 <u>30</u> .. and that death occurred on the date stated above, at <u>1:00</u> p.m. The CAUSE OF DEATH * was as follows: <u>acute Cardiac Dilatation</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> da. Contributory <u>Cholelithiasis</u> Secondary (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> da. (Signed) <u>James Samuels</u> M. D. 192 <u>0</u> (Address) <u>Elkton</u>					
*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> da. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> da. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Colored Cemetery</u>				DATE OF BURIAL <u>March 16</u> , 19 <u>30</u>	
20 UNDERTAKER <u>H. W. J. J.</u>				ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated, thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930

PLACE OF DEATH

County

Cecil

0347

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

Village or City

Near Chesapeake City

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Laura V. Sanders

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

21 12 1858  
(Month) (Day) (Year)

7 AGE

71 yrs. 10 mos. 21 ds. or min.?

If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Kent Co., Ind.

10 NAME OF FATHER

Joshua Covey

11 BIRTHPLACE OF FATHER

(State or country)

Del.

12 MAIDEN NAME OF MOTHER

Elizabeth Aspril

13 BIRTHPLACE OF MOTHER

(State or Country)

Del.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stella Sanders

(Address)

Chesapeake City Md. P.O.

15

Filed

192

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 3

1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

January 3 1930 to January 3 1930

that I last saw her alive on January 3 1930

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

6 hrs.

Contributory Secondary

Arterio Sclerosis

(Duration) yrs. mos. ds.

2

(Signed) Catherine Sanders M. D.

Jan 3 1930 (Address) Cecilton Md.

\*State the 1 is a Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery

Jan. 5 1930

20 UNDERTAKER

ADDRESS

John H. Caffrey

Cecilton, Md.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 7 1930

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1 PLACE OF DEATH County <u>Calvert</u>		06624		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Northeast</u> (No. <u>128</u> )		Registration Dist. No. <u>24</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Alexander Thomas Samuels</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u> <u>Colored</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>May 10</u> , 19 <u>28</u> (Month) (Day) (Year)					
7 AGE <u>2</u> yrs. <u>—</u> mos. <u>27</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>md</u>					
10 NAME OF FATHER <u>Jesse Saunders</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>md</u>					
12 MAIDEN NAME OF MOTHER <u>Clara Cole</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jesse Saunders</u> (Address) <u>North East, Md</u>					
15 Filed <u>6-7-30</u> 19 <u>28</u> <u>Go W. Owens</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 6</u> , 19 <u>28</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 1</u> , 19 <u>28</u> to <u>June 6</u> , 19 <u>28</u> , that I last saw him alive on <u>June 6</u> , 19 <u>28</u> , and that death occurred on the date stated above, at <u>2:05</u> p.m. The CAUSE OF DEATH * was as follows: <u>Acute Papercythemia</u> <u>W. splenic</u>					
(Duration) <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds.					
Contributory Secondary <u>Richards</u>					
(Signed) <u>Jacob H. Saunders</u> M. D. 19 <u>28</u> (Address) <u>21st St. N.E.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>St Marks A. U. M. O. Church</u> DATE OF BURIAL <u>June 8</u> , 19 <u>30</u>					
20 UNDERTAKER <u>Joseph A. Evans</u> ADDRESS <u>North East, Md</u>					



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 3 1920

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Baby

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH December 24<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co. Md.

10 NAME OF FATHER Osceola Layton

11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Laura Kluckian

13 BIRTHPLACE OF MOTHER (State or Country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record

(Address) Elkton Md.

15 Filed DEC 26 1930 F. H. H. H. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH DEC 24, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 24 30 to Dec 30, 1930

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19230

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) V. H. H. H. H. M. D.  
Dec 24, 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry Hill Md.

Dec 26, 1930

20 UNDERTAKER

ADDRESS

H. W. Pippin

Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 7 1931  
BUREAU

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

U.S. No. 1

\* B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			01549		STATE OF MARYLAND	
County <u>Bair</u>			90		CERTIFICATE OF DEATH	
Village or City <u>Blue Bell, Md</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary P. Scarborough</u>			Registration Dist. No. <u>95 93</u>			
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>Dec 30, 1861</u>		(Month) (Day) (Year)				
7 AGE <u>68</u> yrs. <u>1</u> mos. <u>19</u> ds.		if LESS than 1 day, ____ hrs. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Ind</u>						
PARENTS	10 NAME OF FATHER <u>Wm E Scarborough</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>					
	12 MAIDEN NAME OF MOTHER <u>Ann Bugd</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Mr. Frank Anderson</u>						
(Address) <u>Chiles Md</u>						
15 File <u>2-28</u> 19 <u>30</u> Registrar <u>James M. Mawgton</u>						
16 DATE OF DEATH <u>Feb 19, 1930</u>						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Feb 19, 1930</u>						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 25, 1930</u> to <u>Feb 19, 1930</u> .						
that I last saw her alive on <u>Feb 19, 1930</u> .						
and that death occurred on the date stated above, at <u>7 A.</u> m.						
The CAUSE OF DEATH * was as follows: <u>initial Regurgitation of the heart with broken compensation.</u>						
(Duration) <u>3</u> yrs. ____ mos. ____ ds.						
Contributory Secondary <u>none</u>						
(Signed) <u>Chas. H. Miller</u> M. D. <u>Feb. 20, 1930</u> (Address) <u>North East. Ind</u>						
*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>New Leeds Md</u>						DATE OF BURIAL <u>Feb 22, 1930</u>
20 UNDERTAKER <u>Clyde E. Mason</u>						ADDRESS <u>Offord Pa</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary engineer, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Ironing*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH; (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Labor pneumonia*, *Bronchopneumonia*, "Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *septicæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1920  
BUREAU OF VITALS



WRITE ALWAY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

Village or City

Fairhill (No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH 93

Registration Dist. No.

92

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Matthew G. Scarborough

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE

 MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

 June 13, 1863  
(Month) (Day) (Year)

7 AGE

67 yrs. 6 mos. 17 ds. or min.?

 If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Matthew Scarborough

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Price

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. G. Scarborough

(Address)

Eekton, Md RD 5

15

Filed

Jan 2 1931

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 Dec 30, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 20, 1920, to Dec 30, 1920,

that I last saw him alive on Jan 29, 1921,

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH \* was as follows:

Central apoplexy

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

 Herbert Bales M. D.  
1920 (Address) Eekton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sharps Cemetery

Jan 3, 1931

20 UNDERTAKER

ADDRESS

C. J. Chennault

Eekton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1930  
63  
13

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>94</u>	
Village or City <u>North East</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Still born Scarborough</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>Dec 12, 1930</u> (Month) (Day) (Year)				
7 AGE <u>yr.</u> <u>mos.</u> <u>ds.</u> or <u>min.</u> (If LESS than 1 day hrs.)				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>md</u>				
10 NAME OF FATHER <u>Clarence Scarborough</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>md</u>				
12 MAIDEN NAME OF MOTHER <u>Elin Weaver</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clarence Scarborough</u> (Address) <u>North East md</u>				
15 Filed <u>12-17-30</u> 192 <u>E. W. Owens</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Dec. 12, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 12, 1930</u> to <u>Dec 12, 1930</u> that I last saw him <u>dead</u> on <u>Dec 12, 1930</u> and that death occurred on the date stated above, at <u>11 P</u> m. The CAUSE OF DEATH * was as follows: <u>Accident of Childbirth</u> <u>(Instrumental Delivery)</u> (Duration) _____ yrs. _____ mos. _____ ds.				
Contributory Secondary (Signed) <u>C. J. Starnes</u> M. D. <u>Dec 13, 1930</u> (Address) <u>North East, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>North East md</u>			DATE OF BURIAL <u>Dec 17, 1930</u>	
20 UNDERTAKER <u>Joseph R. Grant</u>			ADDRESS <u>North East md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same decepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by acetic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU

JAN 3 1931

N B.--Every item of information should be carefully supplied ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Childs Md R.D. (No. 100-a)

2 FULL NAME Henry T. Schuckler

05445 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH April 13, 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. 1 mos. 11 ds. or 1 day 11 hrs. 1 min. If LESS than

8 OCCUPATION (a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER no Information  
11 BIRTHPLACE OF FATHER (State or country) no Information  
12 MAIDEN NAME OF MOTHER no Information  
13 BIRTHPLACE OF MOTHER (State or country) no Information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Vannie Schuckler  
(Address) Childs Md. R.D.

15 Filed May 26 1920 J. Frank Trayer  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 24, 1930 to May 24, 1930, that I last saw him alive on May 24, 1930, and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH \* was as follows:

Bronchio Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory  
Secondary

Asthma (Duration) 20 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. H. Miller M. D.

May 25, 1930 (Address) North East. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Silverbrook Cemetery, Del. DATE OF BURIAL May 28, 1930

20 UNDERTAKER A. J. Albemarty ADDRESS Elkton, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Droup"; Typhoid fever (never report "Typhoid Pneumonia"; *labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Aschena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1930  
BUREAU V

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		06625		STATE OF MARYLAND	
County <u>Cecil</u>		(124)		CERTIFICATE OF DEATH	
Village or City <u>Cecil</u>		(No. <u>Union Hospital</u> )		Registration Dist. No. <u>42</u>	
2 FULL NAME <u>Nathaniel C. Scotten</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widower</u> (Write the word)			
6 DATE OF BIRTH <u>9</u> <u>10</u> , 188 <u>4</u> (Month) (Day) (Year)					
7 AGE <u>42</u> yrs. <u>9</u> mos. <u>4</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Kent Co. Ind.</u>					
10 NAME OF FATHER <u>Nathaniel C. Scotten</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>					
12 MAIDEN NAME OF MOTHER <u>Margaret A. Stansbury</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Baltimore Ind.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret C. Scotten</u> (Address) <u>Georgetown Ind.</u>					
15 Filed <u>June 16 1930</u> <u>J. Frank Boyer</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 14</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 1</u> , 19 <u>30</u> to <u>June 14</u> , 19 <u>30</u> , that I last saw him alive on <u>June 14</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10 P.</u> m.					
The CAUSE OF DEATH * was as follows: <u>General peritonitis</u>					
Contributory Secondary (Duration) yrs. mos. ds. <u>Abscess of Liver</u>					
(Signed) <u>J. H. Stensbury</u> M. D. <u>6/15</u> 19 <u>30</u> (Address) <u>Cecil Ind.</u>					
*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Salina Cemetery</u> DATE OF BURIAL <u>June 17<sup>th</sup> 1930</u>					
20 UNDERTAKER <u>John H. Coffey</u> ADDRESS <u>Cecil Ind.</u>					

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

Scott

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leucemia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 7 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Beltsville Bld (No. \_\_\_\_\_)

2 FULL NAME Selbold - (still Bells)

0348

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 21, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Unemployed  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cen Co

10 NAME OF FATHER John G. Selbold

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marion Hewson

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. A. C. C. C.  
(Address) 1000 East

15 Filed Jan 22 1930 J. Frank Zager  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on \_\_\_\_\_, 192

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still Bells - about 2 months

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. A. C. C. C. M. D.  
Jan 21 1930 (Address) 1000 East

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

In presence Jan 24, 1930

20 UNDERTAKER ADDRESS

Parents

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1930

BUREAU

RECEIVED



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

12347

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles Miller Sentman,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH February 18th, 1930  
(Month) (Day) (Year)

7 AGE 7 yrs. 13 mos. 13 ds. or \_\_\_\_\_ min.?  
IF LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil County

10 NAME OF FATHER John M. Sentman

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Katherine P. Miller

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Sentman  
(Address) Elkton, Md.

15 Filed Oct 4 1930 J. Frank Taylor  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 1st, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Oct. 1st 30 to Oct. 1st 30  
that I last saw him alive on Oct. 1st, 1923

and that death occurred on the date stated above, at 11.25 P. m.  
The CAUSE OF DEATH \* was as follows:

Convulsions

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.  
Contributory Teething  
Secondary \_\_\_\_\_

(Signed) V. H. One Ringlet M. D.  
Oct. 2nd 1923 Address Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Head Christians Cemetery DATE OF BURIAL Oct 4, 1930

20 UNDERTAKER W. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Intuition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 7 1930

BUREAU

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PLACE OF DEATH		STATE OF MARYLAND	
County <u>Beil</u>		CERTIFICATE OF DEATH	
Village or City <u>Elkton Hospital</u> (No. _____)		Registration Dist. No. <u>9592</u>	
2 FULL NAME <u>Isabelle Naomi Sewell</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>April 22, 1930</u> (Month) (Day) (Year)			
7 AGE _____ yrs. _____ mos. <u>5</u> ds.		If LESS than 1 day _____ hrs. or _____ min.?	
8 OCCUPATION a) Trade, profession or particular kind of work <u>none</u> b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>md.</u>			
PARENTS	10 NAME OF FATHER <u>Grafton Sewell</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Guthrie</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pa.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>M. Grafton Sewell</u> (Address) <u>Rising Sun Md.</u>			
15 Filed <u>Apr 28 1930</u> <u>John M. Northampton</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>4 27, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>4/22 1930</u> to <u>4/27 1930</u> that I last saw him alive on <u>4/27 1930</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>atelectasis</u> <u>not complete</u> (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory Secondary (Signed) <u>Elkton Hospital</u> M. D. <u>4/28 1930</u> Address <u>Rising Sun Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Friends Burying Ground</u>		DATE OF BURIAL <u>April 29, 1930</u>	
20 UNDERTAKER <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit issued 4-28-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis", etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. 3.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

12348

(90)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 94

Village or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annie A. Shallcross

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH November 13 1870  
(Month) (Day) (Year)

7 AGE 59 yrs. 10 mos. 28 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Walbert

11 BIRTHPLACE OF FATHER (State or country) Indiana

12 MAIDEN NAME OF MOTHER Annie E. Brooks

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Margaret Shallcross  
(Address) North East, Md.

15 Filed 10-15-30 Geo W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 11 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 11-1930 to October 11 1930, that I last saw her alive on Oct 11<sup>th</sup> 1930, and that death occurred on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Embolism

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary Chronic Parenchymatous Hypertension (Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) James H. Marshall M. D.  
Oct 14 1930 (Address) Elkton, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

N.E.M.E. Cemetery Oct 15 1930

20 UNDERTAKER ADDRESS  
J. R. Grant North East, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement—never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, and always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"; *Diphtheria* avoid use of "Croup"; *Typhoid fever* avoid use of "Typhoid pneumonia"); *Laborer influenza bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rancher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

NOV 9 1930  
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

06626

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Elkton (No. Univ. Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Annie R. Sharron

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married (Write the word)6 DATE OF BIRTH Nov 26, 1865 (Month) (Day) (Year)7 AGE 64 yrs. 6 mos. 14 ds. If LESS than 1 day hrs. or min.?8 OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Penn10 NAME OF FATHER No Record11 BIRTHPLACE OF FATHER (State or country) No Record12 MAIDEN NAME OF MOTHER No Record13 BIRTHPLACE OF MOTHER (State or country) No Record

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Harry Jones  
(Address) Chesapeake City, Md15 Filed June 13, 1930 J. Frank Bays Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10<sup>th</sup>, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 9<sup>th</sup>, 1927 to June 10<sup>th</sup>, 1930 that I last saw her alive on June 10<sup>th</sup>, 1930and that death occurred on the date stated above, at 9<sup>30</sup> m. The CAUSE OF DEATH \* was as follows:acute Cardiac DilatationContributory Chronic Myocarditis (Duration) 2 yrs. 1 mos. 1 ds.(Signed) Jacob J. Sharron M. D. 192 Elkton, Md (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Tabernacle, Md DATE OF BURIAL June 13, 193020 UNDERTAKER Joseph R. Hunt North East, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women, at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 8 1910  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

U.S. Veterans' Hospital

Village or City Perry Point (No. \_\_\_\_\_)2 FULL NAME SHAW, Paul B.

13709

Maryland

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

C-1 405 109

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH <u>May 9</u> , 1892 (Month) (Day) (Year)
--

7 AGE <u>38</u> yrs. <u>6</u> mos. <u>15</u> ds. or <u>1</u> day <u>1</u> hrs. <u>1</u> min.	If LESS than 1 day _____ hrs. _____ min.
---	--

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>Bookkeeper and salesman</u>
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9 BIRTHPLACE (State or country)	<u>Fairbluff, N. C.</u>
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10 NAME OF FATHER	<u>W. M. Shaw</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>North Carolina</u>
--	-----------------------

12 MAIDEN NAME OF MOTHER	<u>Rose Cogan</u>
--------------------------	-------------------

13 BIRTHPLACE OF MOTHER (State or Country)	<u>North Carolina</u>
--	-----------------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.15 Filed Nov. 25, 19230

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>November 24</u> , 192 <u>30</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept. 10</u> 192 <u>30</u> to <u>Nov. 24</u> , 192 <u>30</u> that I last saw him alive on <u>Nov. 24</u> , 192 <u>30</u>
---

and that death occurred on the date stated above, at 3:40 pm m.The CAUSE OF DEATH \* was as follows:  
General Paralysis, Cerebral Type

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>2</u> mos. <u>14</u> ds. In the State <u>1</u> yrs. <u>2</u> mos. <u>14</u> ds.
---

Contributory Secondary <u>Fracture skull, old, healed</u>
--

(Signed) <u>F. E. LESLIE</u> , Med. Officer in Charge <u>Nov. 25</u> , 192 <u>30</u> (Address) <u>Perry Point, Md.</u>
---

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 2 mos. 14 ds. In the State 1 yrs. 2 mos. 14 ds.

Where was disease contracted, if not at place of death?

UnknownFormer or usual residence 412 Cypress St., Valdosta, Ga.

19 PLACE OF BURIAL OR REMOVAL <u>Undertaker: John Sineath, Valdosta, Georgia</u>	DATE OF BURIAL <u>Nov. 27th</u> 192 <u>30</u>
---	--

20 UNDERKISS Harre de Grace, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CECIL

14877

(31)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Maryland. St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME SHERIDAN, Philip H. XC-326,272

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <b>Single</b>
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6 DATE OF BIRTH <b>May 17, 1895</b> (Month) (Day) (Year)
--

7 AGE <b>35 yrs. 6 mos. 25 ds.</b>	IF LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION  
(a) Trade, profession or particular kind of work **Real Estate Agent**  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) **New York, City, N. Y.**

10 NAME OF FATHER **John Sheridan**

11 BIRTHPLACE OF FATHER  
(State or country) **Unknown**

12 MAIDEN NAME OF MOTHER **Unknown**

13 BIRTHPLACE OF MOTHER  
(State or Country) **Unknown**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Hospital Records,**(Address) **U.S.V.H., Perry Point, Md.**

15 Filed **12/17/30** 192 **Charles W. Madison**  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_, 19230  
**December** (Month) **12** (Day) **1930** (Year)

17 I HEREBY CERTIFY, That I attended the deceased from **February 21, 1930** to **December 12, 1930**, that I last saw him alive on **December 12, 1930**,

and that death occurred on the date stated above, at **4:46 A.M.**

The CAUSE OF DEATH \* was as follows:

**Tuberculosis, Pulmonary, Chronic, Advanced, Active, Type C.**

**Unknown** (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
1. **Laryngitis, Chronic, Tuberculous**  
Contributory 2. **Dementia Praecox, Hebeephrenic type**  
Secondary 3. **Laryngitis, 9 months.** (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) **F. E. Leslie** M. D.  
**F. E. LESLIE** Medical Officer in Charge.  
**Dec. 12, 1930** (Address) **Perry Point, Maryland.**

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. **9** mos. **21** ds. In the State \_\_\_\_ yrs. **9** mos. **21** ds.

Where was disease contracted, if not at place of death? **Unknown**Former or usual residence **43 Cooper Street, Long Island, N. Y.**

19 PLACE OF BURIAL OR REMOVAL **P. Charles Murphy, Undertaker, 337 E. 188th St., Bronx, N. Y.** DATE OF BURIAL **Dec. 15, 1930**

20 UNDERTAKER **R. Madison Mitchell, Havre de Grace, Md.** ADDRESS **15 W. Saratoga St., Balto.,**

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL; septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1921

BUREAU

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City New Pleasant Hill No. \_\_\_\_\_

2 FULL NAME Francis Short

05446 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH March 6, 1845  
(Month) (Day) (Year)

7 AGE 85 yrs. 2 mos. 21 ds. or 21 min. If LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Francis Short

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Aroninda Thomas

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Rebecca Sherman

(Address) Elkton, Md. R.O. 4

15 Filed May 29 1930 Frank J. Jara  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21, 1930 to May 27, 1930.  
that I last saw him alive on May 26, 1930

and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH \* was as follows:

apoplexy

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Paralysis of left side  
Secondary

(Signed) Chas. F. Muller M. D.  
May 28, 1930 (Address) North East. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Rural Cemetery DATE OF BURIAL May 31, 1930

20 UNDERTAKER G. J. Ahernathy ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

2 FULL NAME James Henry Short

St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Dec 27, 1848  
(Month) (Day) (Year)

7 AGE 81 yrs. 8 mos. 19 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Brick mason (retired)  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Elijah Short

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sallie Horace  
(Address) Elkton, Md

15 Filed Sept 17 1920 J. Frank Page Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 16, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 16, 1920, to Sept 16, 1920, that I last saw him alive on Sept 16, 1920,

and that death occurred on the date stated above, at 11 P m.  
The CAUSE OF DEATH \* was as follows:

Chronic myocarditis

(Duration) ? yrs. 1 mos. 1 ds.

Contributory  
Secondary

(Duration) ? yrs. 1 mos. 1 ds.

(Signed) J. Frank Page M. D.  
1920 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ? yrs. 1 mos. 1 ds. In the State ? yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Sept 19, 1920

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Disinfectaria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME James H. Short Sr

10312 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH June 6, 1853  
(Month) (Day) (Year)

7 AGE 77 yrs. 2 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Day Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Franklin Short

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James H. Short Jr

(Address) Elkton Md

15 Filed Sept 6 1930 James H. Short Jr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 1, 1930 to Sept 4, 1930.

that I last saw him alive on Sept 2, 1930.

and that death occurred on the date stated above, at 119 m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Herbert Bates M. D.

9/6 1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery

DATE OF BURIAL Sept 7, 1930

20 UNDERTAKER H. W. Pippin

ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

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1 PLACE OF DEATH County <u>Cecil</u>		66627 (90)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Gebulon Short</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>May 13, 1886</u> (Month) (Day) (Year)					
7 AGE <u>40</u> yrs. <u>6</u> mos. <u>14</u> ds. or min. If LESS than 1 day ____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Md</u>					
10 NAME OF FATHER <u>James Short</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>					
12 MAIDEN NAME OF MOTHER <u>Ann Dickson</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Emma Moore</u> (Address) <u>2202 Jump St</u> <u>Washington Del</u>					
15 Filed <u>June 28 1930</u> <u>James Hays</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 27<sup>th</sup>, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>6/27, 1930</u> that I last saw him <u>dead</u> <u>live</u> on <u>6/27, 1930</u>					
and that death occurred on the date stated above, at <u>S. A.</u> m.					
The CAUSE OF DEATH * was as follows: <u>Acute dilatation of the heart</u> (Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary _____					
(Signed) <u>James Hays</u> M. D.					
____ 192 ____ (Address) _____					
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Criminal. <u>James Hays, Coroner</u>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Elkton Cemetery</u>				DATE OF BURIAL <u>June 30, 1930</u>	
20 UNDERTAKER <u>N. W. Pippin</u>				ADDRESS <u>Elkton Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

1 PLACE OF DEATH County <u>Cecil</u>		06628		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>North East</u> (No. <u>151</u> )		St. _____ Ward _____		Registration Dist. No. <u>94</u>	
2 FULL NAME <u>Samuel Shuttleworth</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widower</u>			
6 DATE OF BIRTH <u>Dec 15 1840</u> (Month) (Day) (Year)					
7 AGE <u>89</u> yrs. <u>6</u> mos. <u>—</u> ds. or <u>—</u> min. 2					
OCCUPATION (a) Trade, profession or particular kind of work <u>Livery business</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired 30 yrs</u>					
9 BIRTHPLACE (State or country) <u>Penna</u>					
10 NAME OF FATHER <u>James Shuttleworth</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Penna</u>					
12 MAIDEN NAME OF MOTHER <u>Evans</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Penna</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Cox</u> (Address) <u>North East, Md</u>					
15 Filed <u>6-17-30</u> <u>Geo W. Owens</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 15 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 14 1929</u> to <u>June 15 1930</u> that I last saw him alive on <u>June 15 1930</u> and that death occurred on the date stated above, at <u>8 20 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Infection of feet and legs</u> (Duration) <u>1</u> yrs. <u>5</u> mos. <u>—</u> ds. Contributory <u>Senile Gangrene</u> Secondary (Duration) <u>1</u> yrs. <u>5</u> mos. <u>—</u> ds. (Signed) <u>C. H. Davis</u> M. D. <u>June 16 1930</u> (Address) <u>North East, Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? _____ Former, or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>North East Mt. Cemetery</u>				DATE OF BURIAL <u>June 16, 1930</u>	
20 UNDERTAKER <u>Joseph A. Davis</u>				ADDRESS <u>North East Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

BUREAU V. 8

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Sarah Virginia Simmons

04176 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 11, 1923  
(Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. 23 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at school  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Irving H. Simmons

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helda May Blackson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irving H. Simmons

(Address) Elkton Md

15 Filed April 4, 1930 J. Frank Taylor Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 30, 1930 to April 3, 1930, that I last saw him alive on April 3, 1930,

and that death occurred on the date stated above, at 11 P. m.

THE CAUSE OF DEATH \* was as follows:

Diphtheria

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 da.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

(Signed) M. P. Morrison M. D.  
April 4, 1930 (Address) Elkton, Md

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Principles Cemetery Md DATE OF BURIAL Apr 4, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# CERTIFICATE OF DEATH

Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ethaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital) St. 8 Ward 92

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

2 FULL NAME Margaret Simmons

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Un? 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 14, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil Co. Md

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Margaret Simmons

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Simmons

(Address) Elkton Md

15 Filed Sept 15, 1930 J. Frank Brown Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, 192

that I last saw him alive on 192, 192

and that death occurred on the date stated above, at 60 m.

The CAUSE OF DEATH \* was as follows:

2 mos miscarriage

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Herbert Baker M. D.

9/14/30 (Address) Elkton Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burial , 19

20 UNDERTAKER ADDRESS

Parents



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugster, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930  
BUREAU

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1 PLACE OF DEATH  
County Cecil

Village or City North East P.O. (No. \_\_\_\_\_)

2 FULL NAME John H. Sumpers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan 4, 1930  
(Month) (Day) (Year)

7 AGE 11 yrs. 11 mos. 11 ds. or 11 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Walter H. Sumpers

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Mary E. Stewart

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter H. Sumpers  
(Address) North East P.O. md

15 Filed 12-8-30 192 Geo. W. Owens  
Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 4, 1930 to Dec. 4, 1930, that I last saw him alive on Dec. 1, 1930, and that death occurred on the date stated above, at 11 A m. The CAUSE OF DEATH \* was as follows:

Acute Bronchitis  
Dilatation  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary Broncho Pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Joseph P. Sumpers M. D.  
192 (Address) North East P.O. md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East M. C. Cemetery DATE OF BURIAL Dec 7, 1930

20 UNDERTAKER Joseph P. Sumpers ADDRESS North East P.O. md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1901  
BUREAU

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1 PLACE OF DEATH County <u>Bear</u>		06017		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>North East Md</u> (No. <u>90</u> )		St. <u>8</u> Ward <u>94</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Nellie F. Simpson</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 21</u> , 18 <u>66</u> (Month) (Day) (Year)					
7 AGE <u>63</u> yrs. <u>7</u> mos. <u>9</u> ds. or LESS than 1 day ____ hrs. ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Penn</u>					
PARENTS	10 NAME OF FATHER <u>William Yorkes</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Penn</u>				
	12 MAIDEN NAME OF MOTHER <u>Ryle</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Penn</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. Frank Simpson</u> (Address) <u>North East Md</u>					
15 Filed <u>6-3-30</u> 192 <u>0</u> <u>E. W. Quinn</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 30</u> , 19 <u>20</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 20</u> , 19 <u>20</u> , to <u>May 30</u> , 19 <u>20</u> , that I last saw him alive on <u>May 30</u> , 19 <u>20</u> , and that death occurred on the date stated above, at <u>2:30 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Chronic Myocarditis</u> (Duration) <u>4</u> yrs. ____ mos. ____ ds. Contributory <u>Auto Phlebitis</u> Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>John J. Simpson</u> M. D. <u>Edith M. Simpson</u> 192 <u>0</u> (Address) <u>North East Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence ____					
19 PLACE OF BURIAL OR REMOVAL <u>North East M. C. Cemetery</u>				DATE OF BURIAL <u>June 3, 1920</u>	
20 UNDERTAKER <u>Joseph R. Simpson</u>				ADDRESS <u>North East Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1920  
BUREAU V. B.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Rowlandville Md (No. \_\_\_\_\_)

2 FULL NAME Pauline Sisk

04177 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH April 11, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland.

10 NAME OF FATHER Arthur Sisk

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Cora Beedy

13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Sisk

(Address) Rowlandville Md.

15 Filed Apr 26 1931

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 25, 1930 to Apr 25, 1930

that I last saw him alive on Apr 26, 1930

and that death occurred on the date stated above, at 3:9 m.

The CAUSE OF DEATH \* was as follows:

Bro pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) W. T. Jones M.D.  
Apr 26, 1930 (Address) Rowlandville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Nottingham Friends April 27 1930

20 UNDERTAKER ADDRESS L. E. Tyson Rowlandville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But, in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 2 1930  
BUREAU

## 1 PLACE OF DEATH

County

Cerie

07918

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Cecil

(No.)

Union Buffalo

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs Elizabeth Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

May 31, 1906

(Month)

(Day)

(Year)

7 AGE

44 yrs. 1 mos. 29 ds. or min.

If LESS than  
1 day... hrs.  
1 day... hrs.  
1 day... hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

Housewife

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Cerie Co Md

10 NAME OF  
FATHER

Joseph Smith

11 BIRTHPLACE  
OF FATHER

(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Mary Brown

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Elizabeth Smith  
Charleston, Md

15

Filed July 30 192

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 29, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 22, 1930 to July 29, 1930

that I last saw him alive on July 28, 1930

and that death occurred on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH \* was as follows:

Acute dilatation of heart

(Duration) yrs. mos. ds.

Contributory  
SecondarySurprise - Hypertension  
for uterine fibroids

(Duration) yrs. mos. ds.

(Signed) M. D.

Jul 24/ 19230 (Address) no int. md

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 7 ds. In the all life

Where was disease contracted, Charleston Md

Former or usual residence Charleston Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charleston, Cerie Co Md

20 UNDERTAKER ADDRESS

Lee A Patterson Cherryville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING  
WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

09133 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

90

Village or City near Warrick (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elizabeth Frances Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

X

6 DATE OF BIRTH February 15

(Month)

(Day)

(Year)

7 AGE

6

If LESS than

1 day \_\_\_\_\_ hrs.

yrs. 10 mos. 10 ds. or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Smith

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Wilmina Presbury

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilmina Smith

(Address)

Middleton Del

15

Filed

8-22 1920

30

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8

21

1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from 8/20 1920 to 8/21 1920that I last saw her alive on 8/21 1920and that death occurred on the date stated above, at 10 m.The CAUSE OF DEATH\* was as follows: Pls. Colic

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. L. Smith M. D.

(Address)

\*State the Disease Causing Death, or, from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Augustine md August 24 1920

20 UNDERTAKER

ADDRESS

S. S. Moore Middleton Del

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Deel



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia?" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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CIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact  
statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER

11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
Secondary

(Signed)

\*State the Disease Causing Death, or in death from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

In the

State

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

04178

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Apr 12 1920

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
March 29 1920 to April 11 1920

that I last saw him alive on April 10 1920

and that death occurred on the date stated above, at 2300 m.  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) W. H. McHugh M. D.

April 12 1920 (Address) College Md.

\*State the 1 is use Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Hæmaturia," "Marasmus," "Old Age," "Shock," "Trichiniasis," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 22 1930

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> Ward)			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>William J. Smith</u>				
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>no information</u>	16 DATE OF DEATH <u>April 26<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>no information</u> , 1- (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from 192 <u>0</u> to <u>4/26</u> , 19 <u>30</u> that I last saw him <u>dead</u> <u>4/26</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>10-A</u> m.	
7 AGE <u>apparent 37 years</u> yrs. mos. ds. or min.?			The CAUSE OF DEATH * was as follows: <u>Fractured Skull and Hemorrhage of Brain</u> (Duration) yrs. mos. ds. <u>Auto accident</u> Contributory Secondary <u>over</u> (Duration) yrs. mos. ds. <u>Howard W. Green</u> (Signed) <u>4/26/1930</u> (Address) <u>Elkton Md</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
9 BIRTHPLACE (State or country)			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.	
PARENTS	10 NAME OF FATHER		Where was disease contracted, if not at place of death?	
	11 BIRTHPLACE OF FATHER (State or country)		Former or usual residence	
	12 MAIDEN NAME OF MOTHER		19 PLACE OF BURIAL OR REMOVAL <u>Martins Ferry Ohio</u>	
	13 BIRTHPLACE OF MOTHER (State or Country)		DATE OF BURIAL <u>Apr 29, 1930</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Union Hospital</u> (Address) <u>Elkton, Md</u>			20 UNDERTAKER <u>H. W. Pippin</u>	
15 Filed <u>April 28 1930</u> <u>J. Paul Trager</u> Registrar			ADDRESS <u>Elkton Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

P.S. - This road about around  
our highway, one mile  
west of North East, Md  
A.W. Allen

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1930

BUREAU OF

## 1 PLACE OF DEATH

County

Elkton

Village or City

(Within Corporate Limits)

(No. ....)

2 FULL NAME

02113 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

94

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Feb. 18<sup>th</sup>

(Month)

(Day)

1930  
(Year)

7 AGE

Prenatal

yrs. 8 mos. ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Elkton

10 NAME OF  
FATHER

Stanley Smith

11 BIRTHPLACE  
OF FATHER

(State or country)

Kent Co.

12 MAIDEN NAME  
OF MOTHER

Bernie Demoray

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Blue Bell Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernie Smith

(Address)

Elkton Md

15

Filed

3/5

1930

Geo W. Amers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 18<sup>th</sup>

(Month)

(Day)

(Year) 1930

17

I HEREBY CERTIFY, That I attended the deceased from

Feb 18<sup>th</sup>

1930 to

Feb 18<sup>th</sup>

1930

that I last saw him alive on Feb 18<sup>th</sup> 1930.

and that death occurred on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH \* was as follows:

Prenatal death

(Duration)

3

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Geo W. Amers M. D.

1930 (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State

yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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(a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 3 1930

BUREAU

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>95</u>	
Village or City <u>Rowlandville</u> (No. <u>14</u> )			St. _____	Ward _____
2 FULL NAME <u>Laura Shellen Somers</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>November 23</u> , 18 <u>62</u> (Month) (Day) (Year)				
7 AGE <u>68</u> yrs. <u>14</u> ds. or <u>14</u> min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Rowlandville Md.</u>				
10 NAME OF FATHER <u>James Shellen</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Louisiana</u>				
12 MAIDEN NAME OF MOTHER <u>Mary Elizabeth Graham</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Rowlandville Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Joseph G. Somers</u>				
(Address) <u>Rowlandville Md.</u>				
15 Filed <u>Dec 8 1930</u> Registrar <u>Ernest R. Montgomery</u>				
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Dec 7</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug 30</u> to <u>Dec 7</u> , 19 <u>30</u> that I last saw her alive on <u>Dec 7</u> , 19 <u>30</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Carcinoma of stomach and intestines</u> (Duration) yrs. <u>4</u> mos. <u>7</u> ds. Contributory <u>Cardiac &amp; haemorrhage</u> Secondary (Duration) yrs. _____ mos. _____ ds. (Signed) <u>Ernest R. Montgomery</u> M. D. <u>Dec 8 1930</u> (Address) <u>Liberty, Maryland</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>md.</u> DATE OF BURIAL <u>Dec 10</u> , 19 <u>30</u> <u>Harmony Chapel</u>				
20 UNDERTAKER <u>J. E. Tyson</u> ADDRESS <u>Besingden Md.</u>				

14879



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worker<sup>1</sup> on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Pay laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 9 1931

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County ecil

Village or City Elkton

(No. Union Hospital)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jane Marie Spencer

Registration Dist. No. 92

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fi 4 COLOR OR RACE no 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Dec 9 1930  
(Month) (Day) (Year)

7 AGE

— yrs. — mos. 1 ds. or — min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country)

md

10 NAME OF FATHER

Geo M. Spencer

11 BIRTHPLACE OF FATHER

(State or country)

Dal

12 MAIDEN NAME OF MOTHER

Berulah Price

13 BIRTHPLACE OF MOTHER

(State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo M. Spencer

(Address) Elkton md

15

Filed Dec 16 1930

John Boyer  
Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Dec 9 1930 to Dec 15 1930.  
that I last saw her alive on Dec 15 1930.

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH \* was as follows:

Failure of closure of  
foremen valve.

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Geo M. Spencer M. D.

192 (Address) Elkton md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John Dal

Dec 16, 1930

20 UNDERTAKER

ADDRESS

P. J. Jones

Memphis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

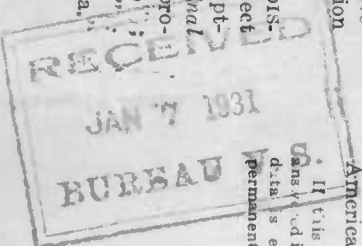
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. "Never return 'Laborer,'" "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the contributory affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"; *Diphtheria* avoid use of "Croup"); *Typhoid fever* (avoid use of "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia).

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retriever wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions asked in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Leecie</u>			Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Andrew M. Spotto</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Aug 17</u> , 18 <u>88</u> (Month) (Day) (Year)				
7 AGE <u>71</u> yrs. <u>5</u> mos. <u>19</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Penn.</u>				
10 NAME OF FATHER <u>Joseph Spotto</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Penn.</u>				
12 MAIDEN NAME OF MOTHER <u>Mary Spotto</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Penn.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. A. M. Spotto</u> (Address) <u>Elkton, Md.</u>				
15 Filed <u>Feb 7</u> 192 <u>30</u> <u>J. H. H. H. H. H.</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Feb 5</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>John 1st</u> 192 <u>7</u> to <u>Feb 5</u> , 19 <u>30</u> , that I last saw him alive on <u>Feb 4</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>5:45</u> p.m.				
The CAUSE OF DEATH * was as follows: <u>Myocarditis</u>				
Contributory Secondary <u>Chronic Myocarditis</u> (Duration) yrs. mos. ds.				
(Signed) <u>John H. H. H. H.</u> M. D. 192 <u>30</u> (Address) <u>Elkton, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.				
Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Friends Cemetery, Calverton, Md.</u>				DATE OF BURIAL <u>Feb 8</u> , 19 <u>30</u>
20 UNDERTAKER <u>G. J. Chemackey</u>				ADDRESS <u>Elkton, Md.</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 6 1930

BUREAU



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14881

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

1 PLACE OF DEATH

County CecilVillage or City North East (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Elizabeth A. Sturgeon

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid  
(Write the word)6 DATE OF BIRTH Sept 21, 1861  
(Month) (Day) (Year)7 AGE 69 yrs. 3 mos. 17 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER David Pennington11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Alexander13 BIRTHPLACE OF MOTHER (State or Country) North East Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Sturgeon(Address) North East Md15 Filed 12/22 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 19, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 12, 1930 to Dec 14, 1930.that I last saw him alive on Dec 14, 1930.and that death occurred on the date stated above, at 10:15 p.m.  
The CAUSE OF DEATH \* was as follows:Polar pneumonia  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 7 ds.Contributory  
Secondary(Signed) Alvin C. Cline M. P.  
Dec 21, 1930 (Address) North East Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East M. E. Cemetery DATE OF BURIAL Dec 23, 193020 UNDERTAKER Joseph R. Gault ADDRESS North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., (*Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU

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1 PLACE OF DEATH County <u>Accr</u>			06629			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Perryville, Md.</u> (No. <u>90</u> )			Registration Dist. No. <u>96</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Julius Stalks</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>June 8</u> , 19 <u>30</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Apr. 1</u> , 19 <u>30</u> to <u>June 8</u> , 19 <u>30</u> that I last saw him alive on <u>June 7</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic Valvular Heart Disease</u> (Duration) <u>3</u> yrs. mos. ds.					
7 AGE <u>about 75</u> yrs. mos. ds. or min.?			If LESS than 1 day hrs. The CAUSE OF DEATH * was as follows:					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>Labourer</u> <u>day</u>			Contributory Secondary (Duration) yrs. mos. ds.					
9 BIRTHPLACE (State or country) <u>Va.</u>			(Signed) <u>J. J. Magraw</u> M. D. <u>June 10 1930</u> (Address) <u>Perryville, Md.</u>					
PARENTS	10 NAME OF FATHER <u>John Stalks</u>		*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
	11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.					
	12 MAIDEN NAME OF MOTHER <u>Frances Harris</u>		Where was disease contracted, if not at place of death? Former or usual residence					
13 BIRTHPLACE OF MOTHER (State or country) <u>Va.</u>		19 PLACE OF BURIAL OR REMOVAL <u>Chestnut Baptist Church</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Luzan Stalks</u> (Address) <u>Perryville, Md. R.F.D.</u>			DATE OF BURIAL <u>June 14 1930</u>					
15 Filed <u>6/12 1930</u> <u>L. J. Sanders</u> Registrar			20 UNDERTAKER <u>Lee A. Patterson</u> <u>Perryville, Md.</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *sc. Shopteumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. 88)

2 FULL NAME Eliza Stanley

05447 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 10, 1857  
(Month) (Day) (Year)

7 AGE 70 yrs. 10 mos. 11 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Levi Green

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Hill

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Stanley  
(Address) Elkton 2nd Rd.

15 Filed May 24 1930 J. Frank Taylor  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1929 to May 21, 1930

that I last saw her alive on May 20, 1930

and that death occurred on the date stated above, at 12:30 p.m.  
The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis  
(Duration) Not known yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary \_\_\_\_\_

(Signed) St. J. Morrison M. D.  
May 24 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery DATE OF BURIAL May 24, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton 2nd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugilist, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 8 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Cherryville (No. 31)

06630 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Gertrude M. Steele

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 11, 1902  
(Month) (Day) (Year)

7 AGE 27 yrs. 6 mos. 6 ds. or 6 min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER Joseph Steele

11 BIRTHPLACE OF FATHER (State or country) Penna

12 MAIDEN NAME OF MOTHER Hattie Kimble

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Steele  
(Address) Cherryville, Md.

15 Filed June 19, 1930 L. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 17, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from June 1, 1930 to June 17, 1930,  
that I last saw her alive on June 16, 1930

and that death occurred on the date stated above, at 2 A. m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) 3 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.  
(Signed) J. F. Magaw M. D.  
June 18, 1930 (Address) Cherryville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cem. DATE OF BURIAL June 19, 1930

20 UNDERTAKER Lee D. Patterson ADDRESS Cherryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Colora (No. \_\_\_\_\_)

2 FULL NAME Cecil Chester Stephens

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 15

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 11, 1877  
(Month) (Day) (Year)

7 AGE 52 yrs. 10 mos. 12 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas Stephens

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Rebecca Millard

13 BIRTHPLACE OF MOTHER (State or Country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora B. Stephens

(Address) Colora Md

15 Filed April 24, 1930 Registrar George W. Nottingham

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. \_\_\_\_.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 23<sup>rd</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,  
that I last saw him alive on 4/25, 1930

and that death occurred on the date stated above, at 10.30 m.  
The CAUSE OF DEATH \* was as follows:

From information  
Accidental traumatism  
by tractor  
Contributory Head & body crushed  
Secondary \_\_\_\_\_

(Signed) Louise M. Nottingham M. D.

192... (Address) \_\_\_\_\_  
\*State the disease causing death, or, in deaths from Violent Causes, state the Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Nottingham Pa DATE OF BURIAL April 26, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Md.

Amur dated April 24, 1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness", etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis", etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit (Don't) St. Ward

2 FULL NAME Stell Born Stewart

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

6 DATE OF BIRTH Jan 31, 1930  
(Month) (Day) (Year)

7 AGE 30 yrs. mos. ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Port Deposit, Md

10 NAME OF FATHER Joseph J. Stewart

11 BIRTHPLACE OF FATHER (State or country) Port Deposit, Md

12 MAIDEN NAME OF MOTHER Mary Worgout Stewart

13 BIRTHPLACE OF MOTHER (State or country) Stamilton, Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Worgout Stewart

(Address) Port Deposit, Md

15 Filed Feb 1 1922 L. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 31 1930 c. to Jan 31 1930, that I last saw h.p.r. alive on Jan 31, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Stell Born -  
Suffocation Cord around neck  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory  
Secondary

(Signed) C. J. Bennett M. D.  
41 1930 (Address) Port Deposit, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL On Premises DATE OF BURIAL Feb 1, 1930

20 UNDERTAKER Father ADDRESS Pokesbury

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

FEB 6 1920  
BUREAU V. 8.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County  Cecil Village or City  Perryville  (No.  100 )2 FULL NAME  William Clifton Stunay 04181 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No.  96 

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Male  4 COLOR OR RACE  white  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  Single   
(Write the word)6 DATE OF BIRTH  March 6, 1930   
(Month) (Day) (Year)7 AGE  1  yrs.  5  mos.  5  ds. or min.? (If LESS than 1 day \_\_\_\_ hrs.)8 OCCUPATION  
(a) Trade, profession or particular kind of work  None   
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country)  Md. 10 NAME OF FATHER  William S. Stunay 11 BIRTHPLACE OF FATHER (State or country)  Md. 12 MAIDEN NAME OF MOTHER  Beulah Owens 13 BIRTHPLACE OF MOTHER (State or Country)  Md. 

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  William S. Stunay   
(Address)  Perryville, Md. 15 Filed  4/12/30  Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  April 11, 1930   
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  April 9, 1930  to  April 11, 1930 , that I last saw him alive on  April 11, 1930 , and that death occurred on the date stated above, at  4 P.  m. The CAUSE OF DEATH \* was as follows: Broncho-Pneumonia   
(Duration)  5  yrs.  5  mos.  5  ds.Contributory  
Secondary(Signed)  J. F. Magraw  M. D.  
 4/12/30  (Address)  Perryville 

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death  1  yrs.  5  mos.  5  ds. In the State  1  yrs.  5  mos.  5  ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  Ashbury Cemetery  DATE OF BURIAL  April 13, 1930 20 UNDERTAKER  See A. Patterson  ADDRESS  Perryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specially the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary); *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Bel Mills (No. \_\_\_\_\_)

2 FULL NAME John W. Stocktail

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH Sept 25, 1851  
(Month) (Day) (Year)

7 AGE 79 yrs. - mos. 7 ds. or LESS than 1 day hrs. min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) Bricklayer

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER John Stocktail

11 BIRTHPLACE OF FATHER (State or country) U.S.A.

12 MAIDEN NAME OF MOTHER No Information

13 BIRTHPLACE OF MOTHER (State or Country) No Information

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Stocktail  
(Address) Bel Mills, Md

15 Filed Oct 3 1930 J. Frank Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 2nd, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 18 1930 to Oct 3rd 1930, that I last saw him alive on Oct 2nd 1930,

and that death occurred on the date stated above, at 7:00 P.M.  
The CAUSE OF DEATH \* was as follows:

Arteriosclerosis  
pyonephrosis, left side

(Duration) 6 yrs. 6 mos. ds.

Contributory Secondary cerebral hemorrhage

(Duration) 6 yrs. 6 mos. ds.  
(Signed) Wallace M. Johnson M. D.  
Oct 3rd 1930 (Address) Newark Delaware

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death hrs. mos. ds. In the State hrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Barnabas Cemetery DATE OF BURIAL Oct 5, 1930

20 UNDERTAKER G. J. Abemathy ADDRESS Cecil, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Creup..."); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 7 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>96</u>	
Village or City <u>Port Deposit,</u>			St. _____	Ward _____
2 FULL NAME <u>John Stricker</u>			STRICKLEN	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Unknown</u>		
6 DATE OF BIRTH <u>Unknown</u>				
7 AGE <u>Husband of Clementine Barnhart</u> If LESS than 1 day... hrs. about <u>50</u> yrs. mos. ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Day</u>				
9 BIRTHPLACE (State or country) <u>North Carolina</u>				
PARENTS				
10 NAME OF FATHER <u>Ashley Stricklen</u>				
11 BIRTHPLACE OF FATHER <u>Raleigh, North Carolina</u>				
12 MAIDEN NAME OF MOTHER <u>Spence McCullers</u>				
13 BIRTHPLACE OF MOTHER <u>North Carolina</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Blanche Green</u>				
(Address) <u>Port Deposit, Md.</u>				
15 Filed <u>12-16</u> 19 <u>30</u> <u>L. L. Sanders</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Dec-11-</u> 19 <u>30</u>				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 7</u> 19 <u>30</u> to <u>Dec-11</u> 19 <u>30</u> that I last saw him alive on <u>Dec 11</u> 19 <u>30</u> and that death occurred on the date stated above, at <u>7:30</u> a.m.				
The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> <u>Paralytic left side</u> (Duration) <u>4</u> yrs. mos. ds.				
Contributory Secondary (Duration) <u>4</u> yrs. mos. ds.				
(Signed) <u>G. J. Benson</u> M. D. <u>1711</u> 19 <u>30</u> (Address) <u>Port Deposit, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death <u>1711</u> yrs. mos. ds. In the State <u>1711</u> yrs. mos. ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Cecil Co. Adams Farm</u>				DATE OF BURIAL <u>Dec 17, 1930</u>
20 UNDERTAKER <u>Lee A. Patterson</u>				ADDRESS <u>Cerryville, Md.</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

UNDER DR. BENSON.  
21/9/13 under Strickland.  
Personal information: See Official.  
JAN 5 1914  
BUREAU V. B.  
SURNAME OF DECEASED CHANGED ACCORDING TO LETTER FILED 9-12-32

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING  
WITH UNFADING INK--THIS IS A PERMANENT RECORD  
WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

10844

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

Village or City Bowlandville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Octava Strong

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 2, 1901  
(Month) (Day) (Year)

7 AGE 29 yrs. 2 mos. 28 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) North Carolina

10 NAME OF FATHER Melvin E. Stridger

11 BIRTHPLACE OF FATHER (State or country) North Carolina

12 MAIDEN NAME OF MOTHER May Reynolds

13 BIRTHPLACE OF MOTHER (State or Country) South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Strong  
(Address) Bowlandville, Md.

15 Oct 2 1930  
Edw. W. Thompson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Sept 15, 1930 to Sept 30, 1930 that I last saw him alive on Sept 30, 1930 and that death occurred on the date stated above, at 11 P m. The CAUSE OF DEATH \* was as follows:

Dr. Asthma  
Chronic Myocarditis  
(Duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) W. T. Back M. D.  
Oct 1, 1930 (Address) Bowlandville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Chapel, Md. Oct 3, 1930

20 UNDERTAKER ADDRESS

F. E. Tyson Rising Sun, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*typhoid fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* avoid use of "Group"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 4 1908  
BUREAU OF VITALS



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Cecil

Village or City Perryville (No. \_\_\_\_\_)

2 FULL NAME Alicia Mitchell Stump

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH October 26, 1854  
(Month) (Day) (Year)

7 AGE 75 yrs. 3 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work H. W.  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER John Stump

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Alicia Mitchell

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Magraw

(Address) Perryville Md.

15 Filed 2/24 1930 J. H. Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 23<sup>rd</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1<sup>st</sup> 1929 to February 23<sup>rd</sup> 1930, that I last saw her alive on February 23<sup>rd</sup> 1930

and that death occurred on the date stated above, at 4:30 m.  
The CAUSE OF DEATH \* was as follows:

Pneumonia of Stomach  
(Duration) 25 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) J. F. Magraw M. D.  
Feb 23 1930 (Address) Perryville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Peter's Cemetery DATE OF BURIAL Feb. 26, 1930

20 UNDERTAKER J. A. Patterson ADDRESS Perryville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*;

(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 7 1930  
BUREAU V. 6

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

13710

(128)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

96

Registration Dist. No. \_\_\_\_\_

Village or City U.S. Veteran's Hospital, Perry Point, Md. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME SWEENEY, John P.C-Unknown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

18911

(Month)

(Day)

(Year)

7 AGE

39 yrs.6 mos.4 ds.If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clerical Worker

(b) General nature of industry business, or establishment in which employed or (employer)

---

9 BIRTHPLACE

(State or country)

Unknown10 NAME OF  
FATHERUnknown11 BIRTHPLACE  
OF FATHER  
(State or country)Unknown12 MAIDEN NAME  
OF MOTHERUnknown13 BIRTHPLACE  
OF MOTHER  
(State or Country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.15 Filed Nov. 18 1930 Charles W. Morrison

Registrar

Dep.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 18,1923

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from  
November 15 1923 to November 18, 1923that I last saw him alive on November 18, 1923and that death occurred on the date stated above, at 12:05 P

The CAUSE OF DEATH \* was as follows:

Acute Nephritis

(Duration)

Unknown

mos. \_\_\_\_ ds. \_\_\_\_

Contributory  
SecondaryAcute Oedema of Lungs

(Duration)

26 hrs.

mos. \_\_\_\_ ds. \_\_\_\_

(Signed)

F. E. Fisher

M. D.

Nov. 18, 1923 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death

yrs. \_\_\_\_ mos. \_\_\_\_ ds. \_\_\_\_

In the  
State

yrs. \_\_\_\_ mos. \_\_\_\_ ds. \_\_\_\_

Where was disease contracted. Unknown  
if not at place of death?Former or  
usual residenceJoppa, Md.

19 PLACE OF BURIAL OR REMOVAL

Howard K. McComas  
Joppa, Md.

DATE OF BURIAL

Nov. 20, 193020 UNDERTAKER Undertaker  
H. K. McComas,

ADDRESS

Abington, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deleter," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia");

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DEC 4 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is forwarded, after thoroughly and as questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

0361 OF 100

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. Union Hospital St. Union Hospital Ward)

2 FULL NAME John Suchy

09135 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH April 9th, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. — mos. — ds. If LESS than 1 day — hrs. or — min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE Balto., Md.  
(State or country)

10 NAME OF FATHER John Suchy

11 BIRTHPLACE OF FATHER Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Mary Domolski

13 BIRTHPLACE OF MOTHER Pa.  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Suchy  
(Address) 2109 Moyer St.

15 Filed Aug 17, 1930 John H. Jager Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 16th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from him dead to 8/16, 1930  
that I last saw him alive on 8/16, 1930

and that death occurred on the date stated above, at 12.30 A.M.  
The CAUSE OF DEATH \* was as follows:

From information -  
Fracture of Skull  
(Duration) Auto Accident yrs. — mos. — ds.  
Contributory Secondary

(Signed) John H. Jager M.D.  
(Address) 192

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  
Fracture of Skull

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the — State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence Balto. - Md.

19 PLACE OF BURIAL OR REMOVAL Balto. DATE OF BURIAL Aug 18, 1930

20 UNDERTAKER John W. Weber ADDRESS Chesford

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. Balto



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilVillage or City U.S. Veterans' Hospital, Perry Point, Md.STATE OF MARYLAND  
CERTIFICATE OF DEATH

02842

60-a

Registration Dist. No. 96

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME TARNOWSKI, John C-626 637

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	--

## 6 DATE OF BIRTH

December 4, 1887  
(Month) (Day) (Year)

## 7 AGE

42 yrs. 2 mos. 28 ds. or min.?

 IF LESS than  
1 day \_\_\_ hrs.  
or \_\_\_ min.?

## 8 OCCUPATION

 (a) Trade, profession or particular kind of work Blacksmith  
 (b) General nature of industry business, or establishment in which employed or (employer) ---
9 BIRTHPLACE  
(State or country)Russia

## 10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.
 15 Filed 3/3 1923 L. Sanders  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

March 1, 1930.

(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from  
June 16, 1927 to March 1, 1930.
that I last saw him alive on March 1, 1930.and that death occurred on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH \* was as follows:

Toxic Goitre.
 (Duration) 2 yrs. --- mos. --- ds.  
 Contributory 1. Auricular Fibrillation.  
 Secondary 2. Chronic Nephritis.

 Type pronounced 3. Dementia Praecox, Hebe phrenic,  
 (Signed) J. E. Leslie 1. 6 wks. 3. 1 yr. 3. 10 yrs. M. D.  
F. E. LESLIE, Med. Officer in Charge.  
March 1, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death 7 yrs. 4 mos. 29 ds. In the State 7 yrs. 4 mos. 29 ds.
Where was disease contracted, if not at place of death? UnknownFormer or usual residence Unknown (no relatives this country)

## 19 PLACE OF BURIAL OR REMOVAL

 Undertaker: Robert Brooks & Son, March 4, 1930.  
Hollins & Carey St., Balto., Md.

## 20 UNDERTAKER

 ADDRESS Pennington & Son, Havre de Grace, Md.

## DATE OF BURIAL

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OFFICIAL USE

9681726 RVM

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

0350

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hospital, Perry Point, Md.St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME TATE, Charles

C-329 202

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <b>Married</b>
----------------------	---------------------------------	--

6 DATE OF BIRTH <b>March 25, 1894</b> (Month) (Day) (Year)
--

7 AGE <b>35 yrs. 9 mos. 29 ds.</b>	If LESS than 1 day... hrs. or min.?
---------------------------------------	-------------------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work <b>Farmer</b> (b) General nature of industry, business, or establishment in which employed or (employer)
---

9 BIRTHPLACE (State or country) <b>N. C.</b>
--

PARENTS	10 NAME OF FATHER <b>Unknown</b>
	11 BIRTHPLACE OF FATHER (State or country) <b>Unknown</b>
	12 MAIDEN NAME OF MOTHER <b>Unknown</b>
	13 BIRTHPLACE OF MOTHER (State or country) <b>Unknown</b>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records,(Address) Perry Point, Md.15 Filed Jan 24 1930 Charles W. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <b>January 23, 1930</b> (Month) (Day) (Year)
---

17 I HEREBY CERTIFY, That I attended the deceased from <b>Dec. 25 1929 to January 23, 1930</b>
---

that I last saw him alive on **January 23, 1930** a.and that death occurred on the date stated above, at **5:50 A. m.**

The CAUSE OF DEATH \* was as follows:

**Tuberculosis, chronic, pulmonary, active, far advanced**

Approximately

(Duration) **2** yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) F.E. Leslie M. D.  
**F.E. LESLIE, Med. Officer in Charge.**  
**Jan. 23 1930** (Address) **Perry Point, Md.**

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, **Unknown**  
if not at place of death?Former or usual residence **Forest City, N. C.**19 PLACE OF BURIAL OR REMOVAL  
**Undertaker: Hovis & Keeser,  
Rutherfordton, N. C.**DATE OF BURIAL  
**Jan. 26, 1930**20 UNDERTAKER  
**Pennington & Son, Havre de Grace, Md.**

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Houseskeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; . . . . . chloremia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemic" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 7 1930  
BUREAU V



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Beebe

Village or City Rowlandville (No. \_\_\_\_\_)

2 FULL NAME Edwin Paschall Taylor

0351

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX man 4 COLOR OR RACE White 5 SINGLE, ☒ MARRIED, ☐ WIDOWED, ☐ OR DIVORCED (Write the word)

6 DATE OF BIRTH May 16, 1850  
(Month) (Day) (Year)

7 AGE 79 yrs. 7 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work carpenter  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Chester Co., Penna.

10 NAME OF FATHER George Taylor.

11 BIRTHPLACE OF FATHER (State or country) Delaware Co., Penna.

12 MAIDEN NAME OF MOTHER Susan Way.

13 BIRTHPLACE OF MOTHER (State or Country) Delaware Co. Penna.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frances Taylor.

(Address) Rowlandville, Md.

15 Filed Jan 6 - 1930 at Rowlandville Registrar Ernest W. Thompson

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 27, 1929 to Jan 3, 1930  
that I last saw him alive on Jan 3, 1930

and that death occurred on the date stated above, at 8 P. m.  
The CAUSE OF DEATH was as follows:

Acute Labor pneumonia

Contributory  
Secondary

(Duration) 8 yrs. 2 mos. 8 ds.  
(Signed) Ernest W. Thompson M. D.  
Jan 6, 1930 (Address) Rowlandville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Nottingham Ind. Jan 7, 1930

20 UNDERTAKER

ADDRESS

L. C. Tyson Rising Sun, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Coal engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 4 1930

MARGIN RESERVED FOR BINDING  
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Seal09136 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95Village or City Rowlandville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Frances F. Taylor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED unmarried  
(Write the word)6 DATE OF BIRTH Sept. 8, 1852  
(Month) (Day) (Year)7 AGE 77 yrs. 11 mos. 20 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmers wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Pennsylvania10 NAME OF FATHER Ashton Flohersty11 BIRTHPLACE OF FATHER (State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Hennetta Lovett13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary C Taylor  
(Address) Rowlandville Md.15 File Aug 29 1930  
West Nottingham Registrar  
Pennsylvania

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 28, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1930 to Aug 28, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred on the date stated above, at 5-4 m. The CAUSE OF DEATH \* was as follows:  
Carcinoma of stomach(Duration) 6 yrs. 6 mos. 1 ds.Contributory  
Secondary(Signed) Ernest R. Paul M. D.  
Aug 28, 1930 (Address) Libertyville Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Nottingham Md. Aug 30 1930

20 UNDERTAKER ADDRESS

J. E. Tyson Rowlandville Md.

If more blanks are needed, Address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material work<sup>1</sup> on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only* (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 2 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County  Cecil

Village or City  Elkton  (No. \_\_\_\_\_)

2 FULL NAME  Harry M. Taylor

10314  
90  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.  92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Male  4 COLOR OR RACE  white  5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  Married   
(Write the word)

6 DATE OF BIRTH  Mch 23 , 18 66   
(Month) (Day) (Year)

7 AGE  64  yrs.  5  mos.  15  ds. or  LESS  than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  Merchant (Grocery)   
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)  Maryland

10 NAME OF FATHER  A. Evans Taylor

11 BIRTHPLACE OF FATHER (State or country)  Maryland

12 MAIDEN NAME OF MOTHER  Rebecca McNamee

13 BIRTHPLACE OF MOTHER (State or Country)  Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  Mrs. Harry M. Taylor

(Address)  Elkton, Md.

15 Filed  Sept 11  19 30   Frank Trager   
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  Sept 8 , 19 30   
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  Sept 7 , 19 30  to  Sept 8 , 19 30 , that I last saw him alive on  Sept 8 , 19 30 .

and that death occurred on the date stated above, at  2 P.  m.

The CAUSE OF DEATH \* was as follows:

Acute cardiac dilatation

Contributory Secondary  Chronic myocarditis   
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)  Herbert Bales  M. D.  
 Sept 9 , 19 30  (Address)  Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elkton Cemetery

Sept 11 , 19 30

20 UNDERTAKER

ADDRESS

H. W. Pippin

Elkton, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1900

BUREAU V. 8

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		90 01552 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Elkton</u> (No. <u>Union Hospital</u> )		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Mary Adaline Templeman</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>	
6 DATE OF BIRTH <u>Nov 24</u> , 18 <u>39</u> (Month) (Day) (Year)			
7 AGE <u>90</u> yrs. <u>1</u> mos. <u>22</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Delaware</u>			
PARENTS			
10 NAME OF FATHER <u>Wm. H. Dushane</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>			
12 MAIDEN NAME OF MOTHER <u>Mary R. Thompson</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. G. Harris</u> (Address) <u>Elkton Md</u>			
15 Filed <u>Feb 17</u> 19 <u>30</u> <u>John H. Trayer</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Feb 16</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 15</u> 19 <u>29</u> to <u>Feb 16</u> 19 <u>30</u> , that I last saw him alive on <u>Feb 16</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10:30 P.M.</u> . The CAUSE OF DEATH * was as follows: <u>Acute Cardiac Dehydration</u> (Duration) yrs. mos. ds.			
Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>John H. Trayer</u> M. D. (Address) <u>Elkton Md</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death Former or usual residence <u>Chesapeake City Md</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery 2nd</u>		DATE OF BURIAL <u>Feb 19</u> , 19 <u>30</u>	
20 UNDERTAKER <u>W. W. Pippin</u>		ADDRESS <u>Elkton Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 6 1930  
BUREAU

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Liberty Grove (No.           )

2 FULL NAME Ella C. Tennant

12350  
101-2  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 9

St.            Ward            (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct 14 1868  
(Month) (Day) (Year)

7 AGE 62 yrs. 0 mos. 14 ds. or            If LESS than 1 day            hrs.            min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)           

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Wm. Glasgow

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Rebecca Proctor

13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Edward Stively

(Address) Liberty Grove MD

15 File 1028 1930  
James M. Southington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 28 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1 1920 to Oct 28 1930  
that I last saw him alive on Oct 28 1930

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH \* was as follows:

Chr Myocarditis  
Chronic Bronchial Asthma  
Chronic Diffuse Nephritis

(Duration)            yrs.            mos.            ds.

Contributory Secondary Chronic Nephritis  
(Duration)            yrs.            mos.            ds.

(Signed) W. G. Fack M. D.  
Oct 29 1930 (Address) Rowland

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death            yrs.            mos.            ds. In the State            yrs.            mos.            ds.

Where was disease contracted, if not at place of death?

Former or usual residence           

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wilmington MD Oct 31 1930

20 UNDERTAKER ADDRESS H. A. Bailey Wilmington

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Permit used 10-28-1930

174

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 4 1930

BUREAU OF VITALS



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PLACE OF DEATH			STATE OF MARYLAND	
County <u>Cecil</u>			01553 CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u>			Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Charles F. Tennis</u>			St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>July 5, 1930</u> (Month) (Day) (Year)				
7 AGE <u>6</u> yrs. <u>7</u> mos. <u>21</u> ds. or min. If LESS than 1 day hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry, business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Ind.</u>				
10 NAME OF FATHER <u>Butler H. Tennis</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Pa.</u>				
12 MAIDEN NAME OF MOTHER <u>Mary E. Fulton</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pa.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Butler H. Tennis</u> (Address) <u>Port Deposit Ind.</u>				
15 Filed <u>2/27</u> 19 <u>30</u> <u>L. Sanders</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>February 26, 1930</u> <u>Feb-26</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb-26-1930</u> to <u>Feb-26, 1930</u> that I last saw him alive on <u>Feb-26, 1930</u> and that death occurred on the date stated above, at <u>7:30 p.m.</u> The CAUSE OF DEATH * was as follows: <u>Lobar Pneumonia</u>				
Contributory (Duration) yrs. mos. ds. <u>5</u> ds. Secondary <u>Scarlet Fever</u> (Duration) yrs. mos. ds. <u>10</u> ds. (Signed) <u>B. Patterson</u> M. D. <u>2/26 1930</u> (Address) <u>Port Deposit Ind.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Little Britain Co. Pa.</u> DATE OF BURIAL <u>Feb 28, 1930</u>				
20 UNDERTAKER <u>See A. Patterson</u> ADDRESS <u>Perryville, Ind.</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Droxy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 7 1930  
BUREAU

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1 PLACE OF DEATH  
County Cecil

13711

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Daniel Starr Terrell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 27, 1878  
(Month) (Day) (Year)

7 AGE 52 yrs. 2 mos. 8 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Pharmacist  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER John M. Terrell

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Ward

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Terrell  
(Address) Elkton Md

15 Filed Nov 8 1930 J. Frank Taylor  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 1920 to November 5, 19230

that I last saw him alive on November 5, 1930

and that death occurred on the date stated above, at 9.55 a.m.

The CAUSE OF DEATH \* was as follows: Hypertension

"Unknown"

Contributory Secondary Cerebral Hemorrhage  
(Duration) About 5 years

(Signed) T. H. Mc Knight M. D.  
Nov 8 1930 (Address) Elkton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Nov 8, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
1 PLACE OF DEATH County <u>Cecil</u>			13712 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Easton</u>			Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Albert S. Thomas</u>			St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
3 SEX <u>m</u>	4 COLOR OR RACE <u>rw.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>	16 DATE OF DEATH <u>Nov 21</u> , 19 <u>20</u> (Month) _____ (Day) _____ (Year) _____	
6 DATE OF BIRTH <u>Sept 5</u> , 18 <u>65</u> (Month) _____ (Day) _____ (Year) _____			17 I HEREBY CERTIFY, That I attended the deceased from <u>July 1</u> , 19 <u>20</u> to <u>Nov 21</u> , 19 <u>20</u> that I last saw him alive on <u>Nov 21</u> , 19 <u>20</u>	
7 AGE <u>65</u> yrs. <u>2</u> mos. <u>16</u> ds. or _____ min.?			and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Cerebral Stenosis</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory Secondary <u>same</u>	
9 BIRTHPLACE (State or country) <u>Penn</u>			(Signed) <u>F. A. White</u> M. D. <u>11-22-30</u> (Address) <u>Lawrence St.</u>	
10 NAME OF FATHER <u>no record</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
11 BIRTHPLACE OF FATHER (State or country) <u>no record</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
12 MAIDEN NAME OF MOTHER <u>no record</u>			Where was disease contracted, if not at place of death? _____	
13 BIRTHPLACE OF MOTHER (State or Country) <u>no record</u>			Former or usual residence _____	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Albert E. Conde</u> (Address) <u>Elkton Md. R.F. 3</u>			19 PLACE OF BURIAL OR REMOVAL <u>Headg Christman</u> DATE OF BURIAL <u>Nov 23 1920</u>	
15 Filed <u>Nov 23</u> 19 <u>20</u> <u>Frank Jones</u> Registrar			20 UNDERTAKER <u>P. J. Jones</u> ADDRESS <u>newmarket</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebro spinal fever* (the only definite synonym is "Epidemic cerebro spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD 2)

2 FULL NAME John Thomas

05446 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Apr 2, 1853  
(Month) (Day) (Year)

7 AGE 75 yrs. 1 mos. 7 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Day Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Farm.

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Rebecca Lotman

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jannette Thomas  
(Address) Elkton 2nd RD 2

15 Filed May 13 1930 J. J. J. J. J. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 8, 1930 to May 9, 1930, that I last saw him alive on May 8, 1930, and that death occurred on the date stated above, at 2.00 p. m. The CAUSE OF DEATH \* was as follows: Chronic Myocarditis

Contributory (Duration) 15 yrs. \_\_\_\_ mos. \_\_\_\_ ds. Bronchial asthma

Secondary (Duration) 15 yrs. \_\_\_\_ mos. \_\_\_\_ ds. (Signed) Just G. G. G. M. D. Address Elkton 2nd

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL The Manor Cemetery DATE OF BURIAL May 13, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton 2nd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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JUN 8 1930  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Becil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Marcella Thomas

01554

(31)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Mar 22, 1913  
(Month) (Day) (Year)

7 AGE 16 yrs. 11 mos. 6 ds. or 1 day 1 hrs. 2 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at school  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Loring Thomas

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hallie Burke

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hallie Thomas

(Address) Elkton, Md

15 Filed Mar 3 1923 Paul H. Bauer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 28, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 10 - 29 to Feb 28, 1920, that I last saw her alive on Feb 28, 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 4 mos. 4 ds.

Contributory Influenza with  
Secondary bronchial pneumonia

(Duration) 4 yrs. 4 mos. 4 ds.

(Signed) V. H. McNeight M. D.

3/1 1920 (Address) Elkton, Md

\*State the 1 is use Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 4 mos. 4 ds. In the State 3 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Burrisville Md

DATE OF BURIAL Mar 3, 1920

20 UNDERTAKER H. W. Pittman

ADDRESS Elkton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		0352		STATE OF MARYLAND	
County <u>Cecil Co</u>		2		CERTIFICATE OF DEATH	
Village or City <u>Richards - Merriand</u>		(No. _____)		Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Henry Dewey Thompson Jr</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Jan 3 1930</u> (Month) (Day) (Year)					
7 AGE <u>Steelborn</u> yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>✓</u>					
9 BIRTHPLACE (State or country) <u>Richards Merriand Cecil Co Md</u>					
PARENTS	10 NAME OF FATHER <u>Henry D. Thompson</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Perryville Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Louisa McVey</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Calora Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry D. Thompson</u> (Address) <u>Perryville, Md.</u>					
15 <u>Jan 4 1930</u> <u>L. J. Sanders</u> FILED REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 3 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY That I attended deceased from <u>Jan 3 1930</u> to <u>Jan 3 1930</u> , that I last saw him alive on <u>Steelborn</u> , 191, and that death occurred on the date stated above, at <u>11 P.M.</u>					
The CAUSE OF DEATH * was as follows: <u>Congenital Spina-bifida with Congenital Hydrocephalus</u>					
Contributory <u>Steelborn</u> Secondary					
(Signed) <u>Ernest Fordland</u> <u>Jan 4 1930</u> (Address) <u>Liberty Merriand</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. ____ mos. ____ ds. to the State, yrs. ____ mos. ____ ds. Where was disease contracted. If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Liberty Cem. Jan 4 1930</u>					
20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Perryville Md.</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tiraia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *ACCIDENTAL*, *SUICIDAL*, or *HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rowler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence—At the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1930

BUREAU V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County CecilSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91Village or City Chesapeake City (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Curtis Harrison Titter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH <u>March 29</u> (Month) (Day) (Year)	<u>1857</u>
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7 AGE <u>73</u> yrs. <u>1</u> mos. <u>7</u> ds. or <u>7</u> min.?	If LESS than 1 day ____ hrs. 1 day ____ hrs. ____ min.?
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8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>Farmer</u>
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9 BIRTHPLACE (State or country)	<u>Maryland</u> <u>Cecil Co., 2nd District</u>
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10 NAME OF FATHER	<u>Isaac Titter</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>Delaware</u>
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12 MAIDEN NAME OF MOTHER	<u>Elizabeth Anderson</u>
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13 BIRTHPLACE OF MOTHER (State or country)	<u>Chesapeake City - Md</u>
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Curtis M. Titter  
(Address) Chesapeake City, Md

15 Filed <u>May 8</u> 19 <u>30</u> <u>B. H. H. Brown</u> Registrar
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>May 6</u> (Month) (Day) (Year)	<u>1930</u>
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17 I HEREBY CERTIFY, That I attended the deceased from April 1st 1930 to May 6 1930, that I last saw him alive on May 4th 1930.

and that death occurred on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH \* was as follows:

Coronary of the Stomach  
(Duration) 1 yrs. 6 mos. \_\_\_\_ ds.

Contributory 2 \_\_\_\_  
Secondary \_\_\_\_  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Catharine Goodson M. D.  
May 6 1930 (Address) Cecil Co. Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery</u>	DATE OF BURIAL <u>May 9</u> 19 <u>30</u>
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20 UNDERTAKER <u>H. W. Pippine</u>	ADDRESS <u>Cecil Co. Md</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essentially and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 4 1930  
BUREAU V

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day... hrs.  
da. or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

02843

(b1-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

Ward)

(If death occurred in  
a hospital or institution,  
give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
1920 to 1920

that I last saw him alive on March 24, 1920

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) M. D.

3/25 1920 (Address) Port Deposit Md

\*State the Disease Causing Death, or, if deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City (No. \_\_\_\_\_)

2 FULL NAME David Tillman

09137

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH no information  
(Month) (Day) (Year)

7 AGE apparent 70 If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Day Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) \_\_\_\_\_

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Anderson

(Address) New Castle Del

15 Filed 8/14 1980 B. Howard Beawn  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_, 1980  
(Month) 8 (Day) 11 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 7-15-30 192 to 8-11-30 192

that I last saw him alive on 8-8-30 192

and that death occurred on the date stated above, at 6: a m.  
The CAUSE OF DEATH \* was as follows:

chronic interstitial nephritis

(Duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Wm. E. Van Norden M. D.  
8/14/30 192 (Address) Chesapeake City, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cecil Co  
Manor Cemetery, Md

DATE OF BURIAL

Aug 14, 1930

20 UNDERTAKER H. W. Rippen

ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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1 PLACE OF DEATH			10315 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>92</u>	
Village or City <u>Elkton</u> (No. _____) St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Alice Crawford Todd</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>		
6 DATE OF BIRTH <u>July 6, 1844</u> (Month) (Day) (Year)				
7 AGE <u>86</u> yrs. <u>2</u> mos. <u>19</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>At Home</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>				
PARENTS	10 NAME OF FATHER <u>James Crawford</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Scotland</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Starkey</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Pennsylvania</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Grace Freeman</u> (Address) <u>Elkton, Md.</u>				
15 Filed <u>Sept 20 1930</u> J. Frank Trager Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Sept 25, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 10, 1930</u> to <u>Sept 25, 1930</u> , that I last saw her alive on <u>Sept 25, 1930</u> , and that death occurred on the date stated above, at <u>81</u> m. The CAUSE OF DEATH * was as follows: <u>Cerebral Apoplexy</u>				
(Duration) _____ yrs. _____ mos. <u>7</u> ds.				
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>Herbert Bales</u> M. D. <u>9/26</u> 19 <u>30</u> (Address) <u>Elkton, Md.</u>				
*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Federalburg, Md.</u>				DATE OF BURIAL <u>Sept 27, 1930</u>
20 UNDERTAKER <u>H. W. Phipps</u>				ADDRESS <u>Elkton, Md.</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, paralysis*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

06631

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 94

Village or City Port Deposit (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annie Grace Ular

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Singl

6 DATE OF BIRTH Dec 28, 1921  
(Month) (Day) (Year)

7 AGE 8 yrs. 5 mos. 17 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work School child  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Louis Ular

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Annada Arrington

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Ular

(Address) North East, md

15 Filed 6-18-30 1922 Geo. W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 14, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 13, 1923, to June 14, 1923, that I last saw her alive on June 14, 1923, and that death occurred on the date stated above, at 2:57 p.m.

The CAUSE OF DEATH was as follows:

intestinal obstruction  
secondary to Peritonitis  
(adhesions)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Acute intestinal  
Secondary Toxemia (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. Richardson M. D.  
June 15, 1923. (Address) Port Deposit, md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North M.E. Cemetery DATE OF BURIAL June 18, 1923

20 UNDERTAKER Joseph R. Shaw ADDRESS North East, md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930  
BUREAU V. 6

WRITE ALLOW, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. 13693) Miss. Hospital St. 92 Ward 92

2 FULL NAME Vandergift (Cebula)Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) -

6 DATE OF BIRTH Nov. 20, 1930  
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 2 ds. or min. LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Cecil

10 NAME OF FATHER Amil Cebula

11 BIRTHPLACE OF FATHER (State or country) Camden, N. J.

12 MAIDEN NAME OF MOTHER Esther Vandergift

13 BIRTHPLACE OF MOTHER (State or Country) Elkton, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amil Cebula(Address) Elkton, Md.

15 Filed Nov 25 1930 J. Frank Ziser Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 20, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 20, 19230 to Nov 20, 19230 that I last saw him live on Nov 20, 19230

and that death occurred on the date stated above, at 2 m. The CAUSE OF DEATH \* was as follows:

Premature Birth  
Stillborn (Duration) 2 yrs. 2 mos. 2 ds.

Contributory Secondary

(Signed) Carol J. Gussmeyer M. D.  
NOV 25 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL own premises

DATE OF BURIAL Nov 20, 1930

20 UNDERTAKER parents

ADDRESS (175)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 5 1930

DEPT. OF HEALTH

1 PLACE OF DEATH

County

Cecil

07919 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton

(No.)

Union Hospital

St:

Ward)

(If death occurred in a hospital or institution, give its NAME in full, street and number.)

2 FULL NAME

Ralph Richard Vasey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 28, 1930  
(Month) (Day) (Year)

7 AGE

— yrs. — mos. — ds. If LESS than 1 day 6 hrs. or 20 min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Ralph Vasey

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Virginia Morris

13 BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph Vasey

(Address)

North East Rd

15

Filed

July 29 1930 J. J. Page

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28<sup>th</sup>, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from July 28<sup>th</sup> 1930 to July 28<sup>th</sup> 1930, that I last saw him alive on July 28<sup>th</sup> 1930, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH \* was as follows:

Failure of Forebrain  
Oral to close  
after birth (Duration) — yrs. — mos. — ds.Contributory  
Secondary

(Signed)

J. J. Page M. D.

192

(Address)

Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

— yrs. — mos. — ds.

In the State

— yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

North East Md Cemetery

DATE OF BURIAL

July 29, 1930

20 UNDERTAKER

H. W. Pippin

ADDRESS

Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 7 1930

WRITE ALL INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Cecil

0353

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

92

Village or City

Edmon

(No.

Union Hospital

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Vasey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Jan 17, 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day 23 hrs.  
yes. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Cecil Co. Md.

10 NAME OF FATHER

Lew Vasey

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Alberta Clark

13 BIRTHPLACE OF MOTHER

(State or Country)

Orleans

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert C. Vasey

(Address)

North East Md

15

Filed

Jan 18

192

J. Frank Hager

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 18, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on Jan 18, 1930,

and that death occurred on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH \* was as follows:

Congenital debility -  
Premature birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

Peritonitis acutal

(Duration) yrs. mos. ds.

(Signed)

Herbert Bates

M. D.

1930

(Address)

Edmon Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Premises

Jan 19, 1930

20 UNDERTAKER

ADDRESS

No

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphena," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

02844

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake City (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edgar Wales

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 ~~SINGLE.~~  
~~MARRIED.~~  
~~WIDOWED.~~  
~~OR DIVORCED.~~  
(Write the word)

6 DATE OF BIRTH February 16, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. 24 ds. or \_\_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Howard Wales

11 BIRTHPLACE OF FATHER (State or country) Millington Ind

12 MAIDEN NAME OF MOTHER Emma Howard

13 BIRTHPLACE OF MOTHER (State or Country) Millington Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Wales  
(Address) Chesapeake City Md. R.D.

15 Filed March 5 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from February 16, 1930 to February 20, 1930, that I last saw him alive on February 20, 1930

and that death occurred on the date stated above, at 11:45 p.m.  
The CAUSE OF DEATH\* was as follows: Malnutrition

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. P. Brown M. D.  
192 \_\_\_\_\_ (Address) Chesapeake City, Md.

\*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cecilton Mts. Cemetery DATE OF BURIAL March 5, 1930

20 UNDERTAKER none ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Paigisteian, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING  
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			10316 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			Registration Dist. No. <u>795</u>	
Village or City <u>Port Deposit</u> (No. <u>R.D. # 2</u> )			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>James Benson Walker</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Boy</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Sept. 23, 1930</u> (Month) (Day) (Year)				
7 AGE _____ If LESS than 1 day 3 hrs. _____ yrs. _____ mos. <u>1</u> ds. or _____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Benjamin Bryant</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Martina E. Walker</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William H. Walker</u> (Address) <u>Port Deposit, Md.</u>				
15 Filed <u>9/25/30</u> 19 <u>30</u> Registrar <u>John H. Thompson</u> <u>Permit 1001</u> <u>11-1930</u>				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Sept. 24, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 23, 1930</u> to <u>Sept 24, 1930</u> that I last saw him alive on <u>Sept 24, 1930</u> and that death occurred on the date stated above, at <u>12 N.</u> m. The CAUSE OF DEATH * was as follows: <u>Premature Blue Baby</u> (Duration) _____ yrs. _____ mos. <u>1</u> ds.				
Contributory Secondary _____ (Signed) <u>R. Benson</u> M.D. <u>Pat Spauldus</u> 19 <u>30</u> (Address) _____				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Hopewell, Md.</u>				DATE OF BURIAL <u>Sept 25, 1930</u>
20 UNDERTAKER <u>J. E. Tyson</u>				ADDRESS <u>Rising Sun, Md.</u>
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory."

Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

3  
BUREAU

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

Village or City Port Deposit, P.D. (No. \_\_\_\_\_)

2 FULL NAME William A. Walker

02845

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 5, 1850  
(Month) (Day) (Year)

7 AGE 79 yrs. 11 mos. 10 ds. or min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hannie Walker

(Address) Port Deposit

15 Filed 3/16 19230 L. J. Sanders  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 25, 1930 to Nov 13, 1930  
that I last saw him alive on Nov 13, 1930

and that death occurred on the date stated above, at 2 A. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage  
Paralysis of left side  
(Duration) 1 yrs. 18 mos. 18 ds.

Contributory  
Secondary

(Signed) E. J. Benson M. D.  
3/15 30 (Address) Port Deposit

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Coppsbury, Cev. DATE OF BURIAL March 17, 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Cerryville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

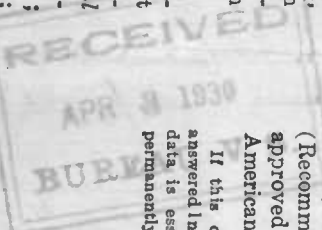
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			020938		STATE OF MARYLAND CERTIFICATE OF DEATH		
County <u>Cecil</u>			(179)		Registration Dist. No. <u>96</u>		
Near <u>Port Deposit</u> (No. <u>    </u> )			St. <u>    </u> Ward <u>    </u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Levie Wallace</u>							
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Feb. 21<sup>st</sup></u> , 19 <u>30</u> (Month) (Day) (Year)				
6 DATE OF BIRTH <u>Sept. 3<sup>rd</sup></u> , 18 <u>57</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from 192 <u>  </u> to 192 <u>  </u> , that I last saw him <u>alive</u> on <u>2/21</u> , 19 <u>30</u>				
7 AGE <u>73</u> yrs. <u>5</u> mos. <u>18</u> ds. or min.?			and that death occurred on the date stated above, at <u>4.30 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Apoplexy - from information - suffered stroke of apoplexy while turning grass in field. Third degree burns - cancer.</u>				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>    </u>			Contributory Secondary <u>From information</u>				
9 BIRTHPLACE (State or country) <u>Md.</u>			Duration <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. (Signed) <u>Lawrence F. Sanders, Registrar, Md.</u> <u>2/22</u> 19 <u>30</u> (Address) <u>Perryville Md.</u>				
PARENTS	10 NAME OF FATHER <u>Geo. F. Wallace</u>		*State the cause of death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Green (Coroner)</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. In the State <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds.				
	12 MAIDEN NAME OF MOTHER <u>Vianna Wilkinson</u>		Where was disease contracted, if not at place of death? <u>    </u> Former or usual residence <u>    </u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>			19 PLACE OF BURIAL OR REMOVAL <u>operating crew.</u> DATE OF BURIAL <u>Feb. 23, 1930</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Selden</u> (Address) <u>Port Deposit, Md.</u>			20 UNDERTAKER <u>Lee A. Patterson</u> ADDRESS <u>Perryville</u>				
15 Filed <u>2/22</u> 19 <u>30</u> <u>L. Sanders</u> Registrar							



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstain, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 7 1930

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <u>Cecil</u>		CERTIFICATE OF DEATH	
Village or City <u>Cecil Mills</u> (No. <u>129</u> )		Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Nathan E. Wales</u>		St. <u>Union Hospital</u> Ward <u>    </u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
<b>PERSONAL AND STATISTICAL PARTICULARS</b>			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>May 7</u> , 1 <u>865</u> (Month) (Day) (Year)			
7 AGE <u>64</u> yrs. <u>10</u> mos. <u>14</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>    </u>			
9 BIRTHPLACE (State or country) <u>North Carolina</u>			
10 NAME OF FATHER <u>Burton Wales</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>			
12 MAIDEN NAME OF MOTHER <u>Martha Phillip</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>North Carolina</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>Mr. Beulah Wales</u>			
(Address) <u>Cecil Mills Md</u>			
15 Filed <u>April 2</u> 19 <u>30</u> <u>J. Brown Trager</u> Registrar			
<b>MEDICAL CERTIFICATE OF DEATH</b>			
16 DATE OF DEATH <u>April 1st</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 31</u> 19 <u>30</u> to <u>April 1st</u> 19 <u>30</u> , that I last saw him alive on <u>April 1st</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>5:30 p.m.</u>			
The CAUSE OF DEATH * was as follows: <u>Chronic Nephritis</u>			
(Duration) <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds.			
Contributory Secondary <u>Unknown</u>			
(Duration) <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds.			
(Signed) <u>V. H. McRae</u> M. D.			
Date <u>April 2</u> 19 <u>30</u> (Address) <u>Cecil Mills Md</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
At place of death <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. In the State <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence <u>Cecil Mills Md</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Clyford, Pa.</u>		DATE OF BURIAL <u>April 5</u> , 19 <u>30</u>	
20 UNDERTAKER <u>G. J. Abernathy</u>		ADDRESS <u>Cecil Mills, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU OF

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. \_\_\_\_\_)

2 FULL NAME Lemard Albert Ward

(113)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 11, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. 4 ds. or 1 day 1 hrs. 1 min.?  
If LESS than

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Bertram Ward

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Rothwell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertram Ward

(Address) Elkton Md

15 Filed Nov 13 1930 J. South Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 11, 1930  
(Month) 11 (Day) 11 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from November 4, 1930 to November 11, 1930

that I last saw him alive on November 11, 1930

and that death occurred on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH \* was as follows:

Diarrhea and Enteritis

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory Secondary \_\_\_\_\_

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) Francis G. Miller M. D.

Nov 12 1930 (Address) Elkton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Md DATE OF BURIAL Nov 13, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

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(a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930  
BUREAU V. S.



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1 PLACE OF DEATH  
County Cecil

Village or City Eekton

2 FULL NAME Mary E. Ward

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH

Aug 6, 1851  
(Month) (Day) (Year)

7 AGE

79 yrs. 3 mos. 27 ds. or min.?

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

House Keeping

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

George H. Burns

11 BIRTHPLACE OF FATHER (State or country)

New York

12 MAIDEN NAME OF MOTHER

Catherine Keith

13 BIRTHPLACE OF MOTHER (State or Country)

Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Ward  
Eekton, Md. R.D.-4

15

Filed

Dec 6- 19230

John H. Gray

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec - 4, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 27-1, 1920 to Dec 4, 1920.

that I last saw him alive on Dec 4, 1920.

and that death occurred on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH \* was as follows:

Septic Caemorene of Left Arm

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory Secondary

Chronic myocarditis

(Signed) John H. Gray M. D.

1920 (Address) Eekton

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry Hill Cemetery Dec. 7, 1920

20 UNDERTAKER

ADDRESS

A. J. Akumathy Eekton, Md.

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 7 1931  
BUREAU V. S.

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1 PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD 2)

2 FULL NAME James A. Warren

02846 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct 2, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 5 mos. 23 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work retired  
(b) General nature of industry business, or establishment in which employed or (employer) Painter & Paper Hanger

9 BIRTHPLACE (State or country) Wisconsin

10 NAME OF FATHER James A. Warren

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Sarah See

13 BIRTHPLACE OF MOTHER (State or country) Wisconsin

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. James A. Warren

(Address) Elkton Md RD

15 Filed March 28 1930 J. Frank Hoyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 20, 1930 to Mar 25, 1930.

that I last saw him alive on Mar 24, 1930.

and that death occurred on the date stated above, at 110 m.

The CAUSE OF DEATH \* was as follows:

Labor Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Herbert Bales M. D.

3/26 1930 (Address) Elkton Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Bethel. Md

DATE OF BURIAL

March 28, 1930

20 UNDERTAKER

J. W. Pappas

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed of given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shoel," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 5 1930

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1 PLACE OF DEATH  
County Cecil

06632

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake City (No. 49)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Laura M. Watson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 20, 1872  
(Month) (Day) (Year)

7 AGE 57 yrs. 8 mos. 24 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Elias Watson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hennette Morgan

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Harry Price  
(Address) Chesapeake City

15 Filed 6/17 1930 B. Howard Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 12, 1930 to June 14, 1930.  
that I last saw her alive on June 14, 1930

and that death occurred on the date stated above, at 4:30 p.m.  
The CAUSE OF DEATH \* was as follows:

Tumor of Bronchus malignant  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Paul H. Small M. D.  
1930 (Address) Elkton Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL June 17, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 3 1930

BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Cecil

Village or City Charlottesville (No.       )

<sup>2</sup> FULL NAME George W. Way

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male  
White  
4 COLOR OR RACE White  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH not known, 1951  
(Month) (Day) (Year)

7 AGE 79 yrs. ☒ mos. ☒ ds. or LESS than 1 day        hrs.        min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER George W. Way

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Hitchcock

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Way  
(Address) Charlottesville, Md

15 Filed 3-24-30 192 Geo. W. Carter  
Registrar

02847

(742)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 21, 1930  
(Month) (Day) (Year).....

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 3, 1930 to March 21, 1930.  
that I last saw him alive on Feb. 14, 1930.

and that death occurred on the date stated above, at 3 P m.  
The CAUSE OF DEATH \* was as follows:

Atherosclerosis  
(Duration) 15 yrs.        mos.        ds.  
Contributory Apoplexy  
Secondary (Duration)        yrs.        mos.        ds.

(Signed) J. F. Magraw M. D.  
March 23, 1930 (Address) Pennville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Charlottesville M. E. Cemetery DATE OF BURIAL Mar 24, 1930

20 UNDERTAKER Joseph R. Grant ADDRESS north East Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 28 1930  
BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			06633		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>			(119)		Registration Dist. No. <u>96</u>	
Village or City <u>U.S. Veterans' Hospital, Perry Point, Md.</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>WEBER, Frederick R.</u>			<u>C-593 384</u>			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>June 16, 1930.</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>December 5, 1898.</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>December 11, 1926, to June 16, 1930.</u> that I last saw him alive on <u>June 16, 1930.</u> and that death occurred on the date stated above, at <u>3:40 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Perforation of the duodenum by swallowed foreign body.</u>			
7 AGE <u>31 yrs. 6 mos. 11 ds.</u> or <u>11 ds.</u> If LESS than 1 day ____ hrs. ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Book binder</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>---</u>			18 APPROXIMATELY 6 yrs. mos. ds. 1. Peritonitis. 2. Dementia Contributory Primary <u>Præcox, Heberphrenic Type, pro.</u> Secondary _____ (Duration) <u>Approximately 3 yrs. 4 mos. 4 ds.</u> Signed <u>F. E. Leslie</u> M. D. Officer in Charge. <u>June 19, 1930</u> (Address) <u>Perry Point, Md.</u>			
9 BIRTHPLACE (State or country) <u>Philadelphia, Pa.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
PARENTS	10 NAME OF FATHER <u>Unknown</u>		15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>3 yrs. 6 mos. 5 ds.</u> In the State <u>Unknown</u> ds. Where was disease contracted, if not at place of death? <u>Perry Point, Md.</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>		Former or usual residence <u>5128 Harlan St., Phila., Pa.</u>			
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>		19 PLACE OF BURIAL OR REMOVAL <u>Arlington National Cemetery, Washington, D. C.</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>		DATE OF BURIAL <u>June 20, 1930.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Perry Point, Md.</u>			20 UNDERTAKER <u>Bemington &amp; Son, Havre de Grace, Md.</u>			
15 Filed <u>June 19, 1930</u> <u>Ed. Charles W. Mackin</u> Registrar						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Render wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 3 1930

BUREAU





# CERTIFICATE OF DEATH

Health Association.)

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**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masles (disease causing death), 29 ds.; Bronchiopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Knife wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

02848

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95

Village or City Plasank Hill (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Emerson Ralph Whalen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH 4 26 1909  
(Month) (Day) (Year)

7 AGE 20 yrs. 11 mos. 4 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Oakwood, Cecil Co., Md.

10 NAME OF FATHER John Whalen

11 BIRTHPLACE OF FATHER (State or country) Chesapeake, Prince Georges Co., Md.

12 MAIDEN NAME OF MOTHER Mary E. Hannum

13 BIRTHPLACE OF MOTHER (State or Country) Epitaph, Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary E. Whalen  
(Address) Edgemoor R. D. 5 Md.

15 Filed Apr 1 1980 Registrar James M. Mordant

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 30 1980  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 29 1980 to March 30 1980, that I last saw him alive on March 30 1980, and that death occurred on the date stated above, at 3:30 P. m. The CAUSE OF DEATH \* was as follows:

Pneumonia lobar - double  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

Contributory None  
Secondary \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) John H. Miller M. D.  
March 30 1980 (Address) North East, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Penn Hill Lancaster Co. Pa. DATE OF BURIAL April 3 1980

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Md.

Permit issued 4-1-80 (930)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

05450

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake City (No. 44)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Oscar Wharton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 31<sup>st</sup>, 1887  
(Month) (Day) (Year)

7 AGE 49 yrs. 10 mos. 15 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day hrs.

8 OCCUPATION Mill Worker  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jas. Henry Wharton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Fyria Borens

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE other

(Informant) Charles R. Wharton

(Address) Chesapeake City Md

15 Filed May 17 1930 Bellwood Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 6 1930 to May 16 1930.

that I last saw him alive on May 15, 1930,

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of stomach

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Herbert Bales M. D.  
5/16 1930 (Address) Cecil Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethel Mt. Cemetery DATE OF BURIAL 5/18, 1930

20 UNDERTAKER Harry G. Lane ADDRESS Chesapeake City Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired—B yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Springer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, "Never return 'Laborer,'" "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telæm*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1900  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

7/5

1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from  
May 1<sup>st</sup> 1930 to July 3, 1930

that I last saw her alive on June 30, 1930

and that death occurred on the date stated above, at 7:49 a.m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed) J. F. Mager M. D.

July 3, 1930 (Address) Perryville

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

0355

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U.S. Veterans' Hosp No. 1, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME WHITE, Harry O. C-1 363 832

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <b>Married</b>
----------------------	---------------------------------	--

## 6 DATE OF BIRTH

March 30, 1895  
(Month) (Day) (Year)

## 7 AGE

34 yrs. 9 mos. 18 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country)Pittsburgh, Pa.

## 10 NAME OF FATHER

William White11 BIRTHPLACE OF FATHER  
(State or country)Germany

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)Germany

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.15 Filed Jan 17 1930 Charles W. Morrison Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 17, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from January 9, 1930 to January 17, 1930that I last saw him alive on January 17, 1930,and that death occurred on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH \* was as follows:

Thrombosis of the Abdominal Aorta.Contributory  
Secondary(Signed) F. E. Leslie (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
F. E. LESLIE, Med. Officer in Charge. M. D.  
Jan. 17, 1930 (Address) Perry Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.Where was disease contracted, Unknown  
if not at place of death?Former or usual residence 3240 Richardson Ave., N.S. Pittsburgh Pa.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Undertaker: Walter Neely,  
Penn. Ave., N.S. Pittsburgh, Jan. 19, 1930  
Pa.

## 20 UNDERTAKER

## ADDRESS

Pennington & Son, Havre de Grace, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil09138 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City Liske (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

John W Whitehead

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH April 19 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 4 mos. 4 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Storekeeper  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER Robert W Whitehead

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Lomax

13 BIRTHPLACE OF MOTHER (State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amos W Whitehead(Address) Leslie, Md

15 Filed 8/27/30 1932 Geo W. Owens  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 6 1930 to Aug 23 1930  
that I last saw him alive on Aug 23 1930

and that death occurred on the date stated above, at 11 A m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory Chronic Interstitial (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Secondary nephritis

(Signed) Ch. H. Haines M. D.  
Aug 24 1930 (Address) North East Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bay View M. P. Church DATE OF BURIAL Aug 27 1930

20 UNDERTAKER Joseph R. Grant ADDRESS North East Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solomon, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mosles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Beech

Village or City Elkton (No. ....)

2 FULL NAME Emma Whittington

02849  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Feb. 10, 1853  
(Month) (Day) (Year)

7 AGE 75 yrs. 1 mos. 1 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed or (employer) at home

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Whittington  
(Address) Cockeys Point, Md.

15 Filed March 19, 1930 J. Frank Ray  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 7, 1930 to Mar 10, 1930, that I last saw her alive on Mar 9, 1930

and that death occurred on the date stated above, at 9:30 a. m.  
The CAUSE OF DEATH \* was as follows:

Germinal pneumonia  
type not known

Contributory Acute bronchitis  
Secondary

(Signed) T. H. McKnight M. D.  
3/10/30 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cokebury Cem DATE OF BURIAL March 13, 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Carriford



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County CecilVillage or City Elkton (No. Union Hospital)2 FULL NAME Walter WilliamsSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH Sept. 10<sup>th</sup>, 1910  
(Month) (Day) (Year)7 AGE 20 yrs. — mos. — ds. or — min. If LESS than 1 day — hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Va.10 NAME OF FATHER Collins Williams11 BIRTHPLACE OF FATHER (State or country) Va.12 MAIDEN NAME OF MOTHER Margaretta Sheppard13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Collins Williams  
(Address) Perryville, Md15 Filed Sept 10 1920 J. Frank Ziegler  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 10<sup>th</sup>, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920,  
that I last saw him live on 9/10, 1920and that death occurred on the date stated above, at — m.  
The CAUSE OF DEATH \* was as follows:from information -  
Septic Pneumonia  
Homicide (Duration) — yrs. — mos. — ds.Contributory  
Secondary  
gunshot wounds  
to the lungs 17 days  
(Duration) — yrs. — mos. — ds.(Signed) Howard W. Green M.D.  
9/10/1920 (Address) Elkton, Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. 1 mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cecil Co19 PLACE OF BURIAL OR REMOVAL Maddenville, Va. DATE OF BURIAL Sept 13, 192020 UNDERTAKER H. W. Pippin ADDRESS Elkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

OCT 6 1930

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Cecil

Village or City Elkton (No. RD)

FULL NAME George Henry Willin

6356

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92 <sup>93</sup>

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Dec 13, 1854  
(Month) (Day) (Year)

7 AGE 75 yrs. 1 mos. 19 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work retired Sea Captain  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER Thomas Willin

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Rachel Reed

13 BIRTHPLACE OF MOTHER (State or Country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W Harry Dawson  
(Address) Newark Del

15 Filed Jan 3 1930 J. Frank Foster Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 28 1929 to Jan 20, 1930

that I last saw him alive on Dec 31, 1929, about a m.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Influenza

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 12 ds.  
(Signed) T. J. McSherry M. D.  
Jan 3 1930 (Address) Elkton-Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL White Clay Creek Cemetery Del

DATE OF BURIAL

Jan 4, 1930

20 UNDERTAKER

H. W. Phipps

ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salomon*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired) 6 yrs*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930  
BUREAU OF VITALS



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Cecil

 10319  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Union Hospital

(No.)

Elkton, Md.

St.

Ward)

 (If death occurred in  
 a hospital or institution,  
 give its NAME in-  
 stead of street and  
 number.)

2 FULL NAME

Hall, Lislemer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

 5 SINGLE,  
 MARRIED,  
 WIDOWED,  
 OR DIVORCED  
 (Write the word)

married

6 DATE OF BIRTH

April 22

(Month)

(Day)

1889

(Year)

7 AGE

73 yrs. 4

mos. 21

ds.

If LESS than

1 day

hrs.

or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

James Hall

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elsie Jane Brock

13 BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helen Bootes

(Address)

Bene Ball Md

15

Filed

Sept 1 1930 J. Frank Taylor

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 13

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Sept. 1

1930

to

Sept 13

1930

that I last saw him alive on

Sept 13

1930

and that death occurred on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH \* was as follows:

 Subacute appendicitis  
 intestinal obstruction

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Pulmonary Embolism

(Duration)

yrs.

mos.

ds.

(Signed)

A. C. Emery M. D.

1930

(Address)

W. H. H. H.

 \*State the disease causing death, or, in deaths from  
 violent causes, state (1) Means of Injury and (2) Whether  
 Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Nottingham Pa. R. D. #3

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oxford Penn

Sept 16 1930

20 UNDERTAKER

ADDRESS

Clyde E. Mason Oxford Pa.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

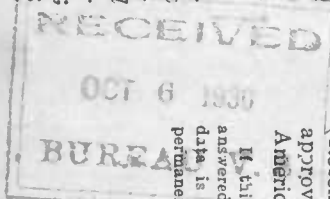
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "N. manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (re tired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
 County Cecil

Village or City Providence (No. \_\_\_\_\_)

2 FULL NAME Lawrence Joseph Wilmer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6 DATE OF BIRTH Aug 20, 1928  
 (Month) (Day) (Year)

7 AGE 1 yrs. 2 mos. 7 ds. or min.?  
 If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
 (a) Trade, profession or particular kind of work none  
 (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William Wilmer

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola Evans

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Viola Wilmer  
 (Address) Eekton, R.D. Md

15 Filed Oct 29 1930 J. Frank Frazer  
 Registrar

12351

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(113)

Registration Dist. No. 9293

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1928, 1930  
Oct (Month) 28 (Day) (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from 1912 to 1928, 1930,  
 that I last saw him alive on 10/22, 1930

and that death occurred on the date stated above, at 12:20 A. M.  
 The CAUSE OF DEATH \* was as follows:

Cholera Infection

Contributory Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Morris Burke M. D.  
1928 1930 (Address) Newark Del.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Shorps Cemetery DATE OF BURIAL Oct 30, 1930

20 UNDERTAKER G. J. Abernathy ADDRESS Eekton, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septiciæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 2 1930  
BUREAU OF

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Perryville No. \_\_\_\_\_

2 FULL NAME Claine Ruth Wilson

09139 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan. 29 1930  
(Month) (Day) (Year)

7 AGE 7 yrs. 7 mos. 1 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edward Wilson

11 BIRTHPLACE OF FATHER Pa  
(State or country)

12 MAIDEN NAME OF MOTHER Etta Beck

13 BIRTHPLACE OF MOTHER Delaware  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Wilson

(Address) Perryville, Md.

15 Filed 8/30 1930 L. F. Sanders  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 9, 1930 to Aug 30, 1930

that I last saw her alive on Aug 24, 1930, and that death occurred on the date stated above, at 1 A m.

The CAUSE OF DEATH \* was as follows:

Slip Periton

Contributory Secondary Exhaustion  
(Duration) yrs. mos. 21 ds.

(Signed) J. N. Steiner M. D.  
Aug 30, 1930 (Address) Harvard Square

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Oxford, Pa DATE OF BURIAL Sept 1, 1930

20 UNDERTAKER W. C. Patterson ADDRESS Perryville Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farm* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Synner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING  
WRITE ALNLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		01555		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cecil</u>		(182)		Registration Dist. No. <u>95</u>	
Village or City <u>near Rowlandville</u> (No. _____)		St. _____		Ward _____	
2 FULL NAME <u>John A. Woodrow</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Feb. 19<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>May 4<sup>th</sup></u> , 19 <u>51</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him <u>dead</u> on <u>2/19</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Drowning: not determined whether accidental or suicidal. No evidence of homicide.</u> (Duration) <u>2</u> yrs. <u>10</u> mos. <u>15</u> ds.		
7 AGE <u>78</u> yrs. <u>9</u> mos. <u>15</u> ds. or <u>LESS</u> than <u>1</u> day <u>hrs.</u> <u>min.</u>					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory _____ Secondary _____ (Duration) <u>2</u> yrs. <u>10</u> mos. <u>15</u> ds.		
9 BIRTHPLACE (State or country) <u>MD</u>			(Signed) <u>Louis M. Cunningham</u> M.D. <u>2/20</u> , 19 <u>30</u> (Address) <u>Rowlandville, MD</u>		
PARENTS	10 NAME OF FATHER <u>Wm. Woodrow</u>		*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>Accidental, Suicidal or Homicidal</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>2</u> yrs. <u>10</u> mos. <u>15</u> ds. In the State <u>2</u> yrs. <u>10</u> mos. <u>15</u> ds.		
	12 M A I D E N NAME OF MOTHER <u>Green</u>		Where was disease contracted, if not at place of death? _____		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>MD</u>		Former or usual residence _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Woodrow</u> (Address) <u>Rowlandville, MD</u>					
15 Filed <u>2/21</u> , 19 <u>30</u> <u>Louis M. Cunningham</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Harmony Chapel</u>		DATE OF BURIAL <u>Feb. 22</u> , 19 <u>30</u>
			20 UNDERTAKER <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Cum gratia issued 2-20-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstean, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Liberty Grove (No. \_\_\_\_\_)

2 FULL NAME Lewis Steury Woodrow

0357

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH July 7, 1885  
(Month) (Day) (Year)

7 AGE 44 yrs. 5 mos. 27 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Cecil Co, Maryland

10 NAME OF FATHER Stephen Woodrow

11 BIRTHPLACE OF FATHER (State or country) Cecil Md

12 MAIDEN NAME OF MOTHER Mathewine Griffith

13 BIRTHPLACE OF MOTHER (State or Country) Cecil Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nina Winchester  
(Address) Liberty Grove, Md

15 File Jan 6 - 1930 Registrar Wm. W. W. W.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1930 to Jan 2, 1930

that I last saw him alive on Jan 3, 1930

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) 4 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) W. T. J. J. M. D.  
Jan 3, 1930 (Address) 29 North St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Nottingham Cemetery DATE OF BURIAL Jan 6, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Md.

Permit issued 1-6-1930

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1930

BUREAU



MARGIN RESERVED FOR BINDING

WRITE ALWAYS, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

13714 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Elkton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Doris Carter Woods

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 21, 1930  
(Month) (Day) (Year)

7 AGE 5 yrs. 16 mos. 16 ds. or 1 day 16 hrs. 16 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Noble H. Carter

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Irene Woods

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Noble H. Carter  
(Address) Elkton, Md.

15 Filed Nov 8, 1930 J. Frank J. J. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21, 1930 to Nov 7, 1930, that I last saw her alive on Nov 5, 1930, and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH \* was as follows:

Spina Bifida

(Duration) 5 yrs. 5 mos. 5 ds.

Contributory Secondary

(Signed) J. T. Morrison M. D.  
Nov 7, 1930 (Address) Elkton, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cherry Hill DATE OF BURIAL Nov 8, 1930

20 UNDERTAKER C. J. Kennedy ADDRESS Elkton, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*;

(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethæmus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU V

WRITE PENCIL WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County Cecil

01556

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City near Bay View (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John W Worth

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept 16, 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 5 mos. 4 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) Retired 1 year

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Isaac Worth

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Simpson

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Harry Worth  
(Address) North East Rd 9 md

15 Filed 2-24-30 1920 Geo W. Queen  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 20 1930 to July 20, 1930  
that I last saw him dead on July 20, 1930  
and that death occurred on the date stated above, at 9:30 P.m.

The CAUSE OF DEATH \* was as follows:

Mitral Insufficiency(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) O. J. Starnes M. D.  
July 21 1930 (Address) North East md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North East M. C. Cemetery Feb 24, 1930

20 UNDERTAKER ADDRESS

Joseph R. Grant North East md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farm* or *Plumber*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebro spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Ansermia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A check data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 4 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

12352

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91Village or City Coyots Corners (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs Katy Wythe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>Feb. 14, 1878</u> (Month) (Day) (Year)
---

7 AGE <u>52 yrs. 8 mos. 17 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION (A) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>Housewife</u> <u>LI</u>
--	-------------------------------

9 BIRTHPLACE (State or country)	<u>Queen Annes Co., Md.</u>
------------------------------------	-----------------------------

10 NAME OF FATHER <u>Unknown Sparks</u>
11 BIRTHPLACE OF FATHER (State or country)
12 MAIDEN NAME OF MOTHER <u>? Unknown</u>
13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) <u>C. D. Jones</u>
(Address) <u>Chesapeake City, Md.</u>

15 Filed <u>Oct. 31, 1920</u>	<u>B. Howard Brown</u> Registrar
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Oct 26, 1920</u> (Month) <u>31</u> (Day) <u>1920</u> (Year)
---

17 I HEREBY CERTIFY, That I attended the deceased from Oct 26, 1920 to Oct 30th, 1920, that I last saw her alive on Oct 30th, 1920, and that death occurred on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

Contributory Secondary	(Duration) ____ yrs. ____ mos. <u>5</u> ds. <u>Chronic bronchitis &amp; emphysema</u>
---------------------------	--

(Signed) <u>C. D. Jones</u>	M. D.
<u>Oct 31, 1920</u> (Address) <u>Chesapeake City, Md.</u>	

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.	In the State ____ yrs. ____ mos. ____ ds.
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Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Cecilton Cemetery</u>	DATE OF BURIAL <u>Nov. 3rd, 1920</u>
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20 UNDERTAKER <u>John J. Caffrey</u>	ADDRESS <u>Cecilton, Md.</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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BUREAU OF VITAL STATISTICS

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

Village or City Chesapeake City Rd (No. \_\_\_\_\_)

2 FULL NAME John Yedinak (YEDINAK)

12353 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 25, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. X ds. or \_\_\_\_\_ min.?  
If LESS than 1 day 5 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Louie Yedinak

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Rosie Jice

13 BIRTHPLACE OF MOTHER (State or Country) Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louie Yedinak

(Address) Chesapeake City Md

15 Filed 10/27 1930 B. Howard Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 25 1930 to Oct 25, 1930.

that I last saw him alive on Oct 25, 1930.

and that death occurred on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH \* was as follows:

Congenital debility

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Secondary Premature delivery

(Signed) Herbert Bates M. D.  
10/26 1930 (Address) Reckless Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Chesapeake City  
St. Rose Catholic Cemetery DATE OF BURIAL Oct 27, 1930

20 UNDERTAKER H. W. Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

NOV 3 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil

66634

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City U. S. Veterans' Hospital, Perry Point, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME ZEPP, Harry G. C297 568

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <b>Single</b>
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6 DATE OF BIRTH  
June 20, 1889  
(Month) (Day) (Year)7 AGE  
40 yrs. 11 mos. 15 ds. or 1 day hrs. min.?  
If LESS than 1 day8 OCCUPATION  
(a) Trade, profession or particular kind of work Railroad laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) --9 BIRTHPLACE  
(State or country) Balto., Md.10 NAME OF FATHER  
Unknown11 BIRTHPLACE OF FATHER  
(State or country) "12 MAIDEN NAME OF MOTHER  
"13 BIRTHPLACE OF MOTHER  
(State or Country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Perry Point, Md.15 Filed June 5 1930 Charles W. Thomas Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
June 5, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
July 1, 1928 to June 5, 1930that I last saw him alive on June 5, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

1. Aortitis. 2. Myocarditis.

3. Hypertrophied and dilated heart.

Duration 1.2 yrs. 2. 2 yrs. 3. 5 yrs. mos. ds.Contributory Secondary Dementia Praecox, HebephrenicType, pronounced. (Duration) 4 yrs. mos. ds.(Signed) T. F. NEIL, Acting Med. Officer in Ch. M.D.  
June 6, 1930 (Address) Perry Point, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 11 mos. 5 ds. In the State Unknown ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Woodbine, Md. Carroll Co.19 PLACE OF BURIAL OR REMOVAL  
Joseph B. Cook, Undertaker, June 9, 1930,  
1003 W. Balto., St., Balto., Md.20 UNDERTAKER  
Pennington & Son, Havre de Grace, Md.

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